

(En)gendering body politics

Physiotherapy as a window on health and illness

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Summary

The aim of this study is to gain knowledge about what patients do to negotiate possibilities and constraints for recuperative encounters with physiotherapists. The historical tenets of Norwegian physiotherapy are recapitulated and contemporary gendered specialisation and work division are presented. **The theoretical underpinning** of the study, critical hermeneutics and the sociology of everyday life, are tied together by coining play as pivotal for understanding and interaction, and by embedding small behaviours as part of language. Hermeneutic understanding depends on the interpreters' background, comprised of symbolic, structural and subjective aspects. **A focus group method** is applied, construed as situated social gatherings: 4 groups of men, 4 groups of women, 26 women, 20 men, aged 18-77, comprising experiences with sports related injuries, chronic pain, heart or lung diseases, physical disabilities or medical unexplained disorders. **Knowledge proposals:** According to the participants, bodily changes and well-being depends on verbal, bodily and hands-on dialogues, and an attentive present therapist. The dialogical situation is precariously constructed; self presentation is planned to details and carefully enacted. Social institutions as gender imprint interaction, understanding and treatment. Pain is construed as action, and is a paradigmatic exemplar of how verbal, bodily and hands-on communication, self presentation and gender intersect in physiotherapy. Independent of age, gender or bodily concerns the participants challenge and negotiate cultural, medical or personal boundaries to enhance well-being and/or to reach personal objectives e.g. increasing pain for a greater good. The participants' accounts are interpreted as intentional human agency, and reconstructed as *body politics*. Construing vulnerability as strength, the participants appreciate some of the benefits gained from living with bodily constraints and challenges. Their actions and enactments create new body idioms and new accounts of health/illness.

Physiotherapy represents a field of practices where contradictory and covert social expectations reside. When social expectations are not met, patients may experience embarrassment, and recuperative interaction may be at risk. Social disruption may be ignored, remedied or laughed at. Laughter may be interpreted as a sign of embarrassment due to fragile interaction. By studying embarrassment and laughter we can listen for social dissonance, and imply some conditions necessary for the interaction to come off. Some necessary conditions are implied above; the participants, as patients, try to avoid embarrassing situations by asserting a personal *body politics* and warranting amendments to the interaction order of therapeutic encounters.

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1. Situating the inquiry

The aim of this study is to inquire into patients' experiences to gain knowledge about possibilities and constraints for recuperative encounters with physiotherapists, and to learn how they conceive of and enact health and illness. With particular reference to gender, the study seeks to identify resources that can be used to make new purposes possible.

This chapter presents the study's background, the research questions, the philosophy of science paradigm chosen, a select literature review, and present the thesis structure.

The subject matter of the study

The study *(En)gendering body politics. Physiotherapy as a window on health and illness* depart from the participants' experiences with physiotherapy and other health services at large. Physiotherapy is conceived of as a social practice, where embodied knowledge and social institutions are put to play. Social and cultural expectations are both enabling resources and constraints upon agency, i.e. the condition of being in action, and the means or mode of acting building on understanding of the situation at hand. The participants' accounts of health and illness illuminate how they negotiate their life conditions to enhance health and well-being at the level of everyday living, by amongst other things appropriating physiotherapy.

As I have suggested elsewhere, female physiotherapists enact their professional duty by taking particular care to avoid disruptions in the situational definition of therapy. This is accomplished by means of countless small behaviours, emotional work, and metaphorical and practical adaptations. Gender is both an enabler and a constraint to situational definition and interaction (Sudmann 1998). The former study revealed some of the female therapists' enactments to make bodily and metaphorically proximity to their patients possible. The present study, *(En)gendering body politics*, aims to learn more about how the patients relate to and enact physiotherapy. Physiotherapy is a more or less welcome activity in their daily rounds. This thesis will show that the patients' doings in relations to physiotherapy more often than expected, ramifies into considerable parts of their lives. Or rather; that bodily concerns ramify into most parts of everyday living, wherein physiotherapy may be a small,

but significant entity. Personal agency and multiple understandings of health, bodily concerns and well-being are important aspects of how patients negotiate and enact physiotherapy.

Research questions

Based on the participants' stories about encounters with physiotherapists and other health care agencies, this thesis presents some answers to the question:

- What do patients *do* to negotiate enabling and constraining aspects of therapeutic encounters, with particular reference to gender?

The working title of this study has been "*How is gender done in physiotherapy?*" This title intended to direct attention to patients' agencies and enactments, and the significances of gender. The main research question was paraphrased into four sub-questions, which served as guidelines when the empirical material was created in the group discussions, and later when analysed.

- i) How is the bodily interaction enacted?
- ii) How do patients relate to social and cultural imperatives of self presentation when encountering physiotherapy?
- iii) How do patients relate to social and cultural expectation of the physiotherapist's self presentation?
- iv) How do social and cultural expectations or imperatives of mutual self presentations affect the relationship between therapist and patient, and the therapeutic content?

All participants were given a short outline of the study, which included project working title, aim of study and research questions as listed above (see Appendices, in Norwegian).

Personal and professional background

As a researcher, I am socially and historically situated in my experiences and my pre-understanding and knowledge as a woman, a former physiotherapist and as a social scientist. This background represents both the premises and the boundaries of the research process –

from identifying a fruitful research question, interpreting the empirical data, and writing a report on the findings. The social institution of gender provides resources and constraints upon me as a researcher – as it does upon all member of our society. Inquiring into gendered significances may make the researcher's gender relevant as well.

I worked some years as a physiotherapist in the late 80ies. By and large my clinical work experience is gained at a university hospital, part time working with children or adults who suffered from severe neurological injuries or disorders, and part time tutoring students at all departments. I have not worked in a private clinic. The participants in this study have gained most of their experiences with physiotherapy or other health care services outside the realm of university hospitals, frequently in private clinics or the like. By numbers, their ailments and disorders are “common” and general, whereas my working experiences are from an area of “the uncommon” and the particular. Additionally, two of the groups are comprised of athletes. I do not have any professional or personal experience from sports or athletics.

The research question has grown from my professional experiences as a physiotherapist, and the findings of my former study of female physiotherapists. My curiosity, however, was directed at the social interaction as such, not towards physiotherapy as a particular practice or science. I believe that professional experience enabled me to pose these particular questions, i.e. being a physiotherapist focused my attention and curiosity in particular ways. The fact that I have left the profession, however, enables me to interpret the empirical material as a social scientist. Obviously, this makes me perceive the subject matter in other ways. The participants have surprised me several times, and the analyses suggest that bodily disorder, age and gender cut across acknowledged divides with respect to health and illness.

This study is located in the realm of disability studies research, which encompasses the sociology of the body, and the sociology of health and illness. The knowledge claims I will make, may serve as a contribution to the body of knowledge in physiotherapy, but my claims are probably better suited to contribute to the body of knowledge gained from disability studies research and from sociology of health and illness.

Physiotherapy as a gendered social practice

This section gives reason for the study's particular interest in gender. First, the gendered profile of the Norwegian physiotherapy profession is introduced; second, the case of massage is used to illuminate the ambiguity in hands-on therapy; and the third sub-section gives reason for approaching physiotherapy as a social practice.

Gender and physiotherapy

The Norwegian physiotherapist and sociologist Rannveig Dahle has contributed considerably to inquiries into physiotherapy as a social practice, theoretically scrutinizing physiotherapy as a profession, and making problematic the tangible gendered aspects of Norwegian physiotherapy. Dahle's doctoral thesis *Work division, Power, Identity: The Impact of Gender in the Physiotherapy Profession*, is a distinguished contribution to the sociological body of knowledge on Norwegian (gendered) physiotherapy (Dahle 1990). Dahle applies insights into women's studies in the 1980s to the history of physiotherapy; i.e. conceiving organisation of society, families and profession as a patriarchal system with male domination and female subordination at its centre. Her conclusions are that gender has an impact on how a profession re-presents and situates itself among other professional organisations, and that gendered work division is built on and reproduced within the profession of physiotherapy as different ideologies and theoretical definitions. The female therapeutic model encompasses a caring rationality (compassion and feelings), with the male model characterized by an ends and means rationality (efficiency, control). Following Dahle, these strategies are cognate with cultural conceptions of femininity and masculinity.

Dahle has written several articles on gender, sexuality and power, and questioned the profession's defensive tabooing of these issues (Dahle 1984a; 1984b; 1991; 1992; 1995; 1996; 1997; Dahle & Vannes 1985). Her work has inspired my inquiry. Macro sociological studies provide a fruitful departure for inquiries into gender or power at an individual level. However, her studies need to be complemented with micro sociological studies from the patients' point of view – to allow claims to be made on how structural and cultural representations of gender and power are played out and interpreted *in situ*.

Enger construes specialization in physiotherapy as creating considerate, patient female physiotherapists and efficient, impatient male physiotherapists (Enger 2001). Her argument is built on an interview study of six physiotherapists in three different specialities, and on statistical data. Both men and women, when in a minority in their specialisation (men in psychomotor or child physiotherapy, and women in orthopaedic manipulative treatment), handle this position by means of two different strategies. One strategy is to modify the gender identity, i.e. call attention to cultural gender signs given to the opposite sex. The other strategy is to modify the speciality; i.e. adding gender qualities from the minority sex. Enger is surprised by the conspicuous absence of discussion of the gendered work division in physiotherapy. Dahle remarks that in the early years of physiotherapy, there was a blind faith in gender-neutral professional strategies (Dahle 2001). She argues that evolution of the profession will be hampered without a discussion on gender. Gender neutrality veils differences between men and women, and disguises power relations. The conflict surrounding the male manipulative therapist gives reason to pay attention to Dahle's arguments and recommendations. Chapter two details work division in Norwegian physiotherapy further, and briefly recount the history of Scandinavian physiotherapy.

The never-ending story – the question of massage

Hands-on therapy, as massage, has been an ambiguous issue in physiotherapy. The head of the physiotherapy college at Bergen became well known for her slogan in the late 1970s and early 1980s: "Less massage, more health promotion!" (Haugen 1997:263, 266). This was in many ways a suggestive description of how massage has been handled in physiotherapy over the years. It has been treated with ambiguity, as an issue seen as inferring and interfering with identity, pleasure and gender – the one we love to hate, or hate to love. The new college at Bergen differed from the ones in Oslo in several ways. The term 'soft tissue treatment' replaced the term 'massage', and the curricula focused on health promotion and physical activity. The Bergen College was the first to include research methodology in the programme. There was no regular outpatient clinic at the college as there was in Oslo at the time.

The Mensendieck College at Oslo did not teach their students massage techniques before 1974, when it became mandatory to fulfil the requirements to use the title physiotherapist. The phenomenon of massage is, in everyday life, connected with pleasure. Massage is used in

kindergartens where children are taught to massage each other, parents massage their infants to calm them down, massage is given to terminally ill people by their loved ones or professionals, and massage is recommended to enhance intimate relations. Whenever somebody takes pleasure in being massaged, someone else has to do the massaging. Massage is communication, both parties feeling each other in real time, and can be conceived as a situation of trust and comfort, as well as a sexual interface (Ekerholt & Bergland 2006; Hicks-Moore & Robinson 2008; Moyer & Rounds 2008; Nicholls & Cheek 2006; van der Riet 1995; van der Riet 1998). Following Dale, trailing the history of massage in Norway uncovered a class-related phenomenon. Masseuses came from the working classes, had little or no education, whereas the medical gymnasts were upper-class, educated women (Dahle 1990:86). This mixture of class, massage, pleasure and prostitution has obviously had an impact on the phenomenon's conceptualisation and perception – both among professional and lay people – in Norway and elsewhere, in this case United Kingdom (Nicholls & Cheek 2006).

Massage has until recently not been acknowledged by medicine as a proper form of treatment, an opinion underpinned by reference to the ostensible lack of objective evidence of effective outcome. The first authoritative textbook on the matter was published in 1997, second edition in 2003, treating massage as 'a manipulation of the soft tissues of the body by a trained therapist as a component of a holistic therapeutic intervention' (Holey & Cook 2003:6). Contemporary textbooks in therapeutic touch and massage seldom pay much attention to the question of ambivalence and ambiguity, or to the relational and communicative aspects of giving and receiving massage or soft tissue treatment. Holey & Cook do not mention emotions, gender, sexuality or any topic related to this. A biomedical paradigm is predominant. Publications on the matter in physiotherapy are otherwise scarce. Ekerholt & Bergland's paper elucidates patient's experiences with psychomotor physiotherapy. Ambiguity emerged as an important category, along with the intra- and interpersonal dialogue. Pleasure and provocation, losing and gaining control interchanged (Ekerholt & Bergland 2006).

Interestingly, a few publications relevant to this study, are published in journals as *Nursing Inquiry* (van der Riet 1995; van der Riet 1998), *Dementia* (Hicks-Moore & Robinson 2008) and *Journal of bodywork and movement therapies* (Moyer & Rounds 2008), where sexuality is discussed – as a resource and as a constraint. Moyer & Rounds' 'The attitudes toward

massage scale' call attention to the fact that massage and fear of sexual arousal may stay in the way of trying massage for some persons. Sexuality and gender appear important in relation to massage (Moyer & Rounds 2008), an issue supported by van der Riet's studies. Hicks-Moore & Robinson's study underscores the impact of hands-on treatment, and demonstrates how massage and music calm down agitated patients, and purports well-being.

To my knowledge, students in physiotherapy and physiotherapists and their spouses/cohabitants are often teased by friends about the pleasure partners' gain from professional massage – leaving no doubt about the sexualized connotation of the phenomenon. In addition, there is a huge amount of anecdotal "evidence" of blurred boundaries between therapist and patients. Physiotherapists, who remember their history (see next chapter), can look back to a century with physiotherapeutic massage commingled with sexual intimacy, and it seems to continue for yet another century. This is made problematic by competing understandings of health; e.g. when health is equated with well-being (Sarvimäki 2006; Svenaeus 2000e). Taking pleasure in massage or hands-on treatment may be interpreted as a prerequisite for recuperative therapy. I will return to this issue several times.

Social practice – social institutions

The headline of this section, physiotherapy as social practice, can be interpreted as a contradiction in terms, according to some voices in a recent debate in the Norwegian physiotherapy journal. Several physiotherapists were debating an article describing personal experience of body awareness therapy (Gretland 2001a; Gretland 2001b; Hvidsten 2001; Rosenvinge 2001; van der Meijde 2001). There were two main arguments, first, that using one's own experiences as empirical material is allegedly impossible and non-scholarly, and second, that the article's author had misunderstood the concept of body awareness therapy and presented a misleading picture. The critics did not pick up on the interesting academic claim, but directed their attacks directly at the Author. Regrettably, this is a classic situation when unfamiliar arguments are brought to the Academy or to the field of Practice. The debate is not my point, but it illustrates an unconventional use of social science methodology in physiotherapy, in particular making the 'I' in science visible (Brown 1996). My purpose when participating in the debate was to call attention to differences and similarities between everyday practice and physiotherapy practice, and press for more studies

of physiotherapy as social practice, and a more generous and curious reception of other articles in the same vein (Sudmann 2001a).

Within an interpretive paradigm, all social relations are historically situated, and are constituted through negotiations and renegotiations, the nature of which varies according to context. People vary in relation to multiple dimensions and traits. The social imperatives of immediate stratification and categorization do not apply the full vocabulary all the time. Some or more of the similarities and differences between us are made relevant, and as a result have an impact on relationships. However, it can be quite difficult to predict which of them will have the greatest impact. Social statuses such as gender, ethnicity, sexual preferences, social class, family and age, align with individual differences in, for instance, clothing, dialect, accent, vocation, disability, smells and so forth, and enable or constrain the actors (Bauman & May 2001; Goffman 1959; Goffman 1963b; Goffman 1983; Grusky 1994; Martin 2004). Consequently there will always be several aspects of difference to be dealt with in social interaction.

In one of the chapters in *Physiotherapy at the threshold* (Stokkenes, Sudmann, & Sæbøe 2001) we tried to show that if the therapist is only focused on the individual patient, and neglects all collective or structural dimensions, it leads to a particular kind of blindness. An exclusive focus on the individual may conceal structural differences and patterns (Sudmann & Råheim 2001b). Studying physiotherapy as social practice inevitably leads to addressing the individual and their structural context, along with intersecting and interfering social orders.

Conducting the project *(En)gendering body politics*, I have tried to follow two well known recommendations: “If you want to know how I am, ask me!” and “Nothing about me without me!”, often used by blacks’ and women’s liberation movements to call attention to all kinds of biases inherent in the imposed images of their lives and experiences produced by others. From a critical hermeneutic perspective, it is obvious that the ones who turn to physiotherapists for treatment are the only ones to tell about their personal experiences afterwards. A few decades ago, the medical establishment, including physiotherapy practice, often claimed to know better than the patient regarding complaints, treatments regimens and outcome measures. Being a professional was equated with being situated at a particular

vantage point as a privileged knower. Contradictory statements from the patients were subscribed to lack of compliance, lack of a cooperative attitude and so forth. During the last two decades critical arguments from activist organisations and critical research have abounded, several whitepapers are issued, and new statutes are in force to strengthen citizen perspectives and prevent discrimination. These are core issues for disability studies researchers (Davis 2006; Devlin & Pothier 2006; Shakespeare 2006; Thomas 2007; Watson 2008).

However, according to the participants in this study, some professionals still claim a privileged knowledge position, often acting under cover of “shared clinical decision-making” or more explicitly by systematically ignoring patients’ points of view. Challenged and moved by patients during some years as a physiotherapist, getting to know disability activists, and later on inspired by critical and feminist research traditions, I have turned to the patients¹ to inquire about and listen to their stories about physiotherapy.

Social institutions, as gender, represent background resources which the interacting parties in therapy can make use of and draw on, and which makes autonomous agency possible (Kögler 2006). Within the field of physiotherapy, there is a small but slowly growing body of gender related research, all situated within a larger frame of an interpretive paradigm, encompassing amongst other issues, interpretive sociological thinking (Bauman & May 2001; Crow 2005).

Physiotherapy as...

This section presents a select body of physiotherapy related research. There are few studies of physiotherapy as a profession, or critical accounts of the events surrounding the emergence of one of the largest health professional groups in Western healthcare (Nicholls & Cheek 2006). Moreover, sociological studies of physiotherapy are conspicuously scarce. However, the body of knowledge in physiotherapy contain a few Scandinavian studies of particular relevance to the present study. Ek, Engelsrud, Rosberg and Thornquist’s studies are cognate micro sociological studies of treatment situations, informed by phenomenological thinking (Ek 1990; Engelsrud 1990; Rosberg 2000; Thornquist 1998). All four scholars demonstrate

¹ I have settled on the term patient as a generic term to describe the person attending a physiotherapy session. The concept of patient is used in legislation regulating physiotherapy and other health practices, despite being much disputed and discussed outside the health care establishment. The participants in this study are not *patients* as such, but their experiences are gained *as patients*.

how the relation between the interacting parties has a distinct impact on the practice. Dahle (1990), who is presented in the section above, particularly made problematic the gendered making of the Norwegian physiotherapy profession. Additionally Thing, a Danish sociologist, have studied the body regimens in the physiotherapy clinics (Thing 2005a;Thing 2005b;Thing 2006). The respective studies and their relevance for my study are outlined below.

... communication

In her doctoral thesis *Physiotherapy as Communication: Microanalysis of Treatment Situations*, Ek (1990) questions the patient–therapist relationship, asking what is therapeutic about treatments, and how knowledge is gained. She argues that treatment situations need to be conceptualized as jointly produced by the patient and therapist moment by moment in real-time and as occasions where knowledge is created. As Ek explains:

During treatment the patient and the therapist are present to each other moment by moment and they take account of each other's actions. Both of them are active and reflecting human beings. Both of them have intentions and knowledge, although of different kinds. Both of them teach and learn. [...] The assumption also encompasses the idea that the patient's knowledge and the therapist's knowledge are of little value when isolated from each other, but when they intermingle during the course of treatment they are of the utmost importance in leading to the creation of new knowledge. (Ek 1990:2)

Ek's perspective was quite original when advanced. Unfortunately, she did not live long after this publication. Her perspective is recently applied in a new study by Iversen, Øien and Råheim (2008). They explored communicative meanings in treatment of disabled children in physiotherapy. Their study highlights the importance of moment by moment mutual creation of varying communicative patterns. This communication pattern had a direct impact on the children's experience of overall meaning in the situation as well as on their quality of movement (Iversen, Øien, & Råheim 2008). Their common highlighting of moment by moment mutual creation of therapy tells of a hermeneutic event, where the interactive parties negotiate the situation at large through dialogical and bodily interaction.

... movement

Engelsrud's primary concern in her doctoral thesis *Love and Movement. Fragments of an Understanding of Physiotherapy*², is how the body is acknowledged in physiotherapist-patient relations (Engelsrud 1990). As Ek, her construes of physiotherapy were quite original and often unintelligible to Norwegian physiotherapists when forwarded. She introduces the living body as an epistemological position for physiotherapy practice. By developing a reciprocity between being a body and doing something with the body, the therapist can conceive of herself as participator and co-creator of the treatment. Experiences acquired during treatment will stimulate the personal development of both patient and therapist – and make new purposes possible Engelsrud argues.

Engelsrud has done extensive work on the issue of 'body and movement' theoretically as well as practically. She is concerned with promoting bodily experiences as favourable terms in physiotherapy (Engelsrud 1997;Engelsrud 1998a;Engelsrud 1998b;Engelsrud 2000;Engelsrud 2001;Engelsrud 2005a;Engelsrud 2005b;Engelsrud & Lilleaas 1999). She argues that the multidimensionality of bodily experiences offers a particular opportunity for learning, both for the therapist and the patient. This argument ties into Ek's claims. Along this line of argument, the therapist has to be bodily attuned and sensitive towards the patient, and be prepared for her own and her patient's non-reflected bodily memories. By letting the body be experienced in new ways, e.g. as a living, fragile, unstable, powerful, dramatic site, susceptible to its life conditions, new knowledge and self-healing potential can emerge, and bodily trust can be restored. Engelsrud's arguments on bodily trust and self-healing reflect basic preconditions for a hermeneutic of medicine, health and well-being (Gadamer 1996; Svenaeus 2001). More important, with regard to the present study, these arguments suggest personal agency and well-being as prerequisites for recuperative therapeutic encounters.

... a relational body

Susanne Rosberg outlines several important issues concerning interaction and creating of meaning during physiotherapy. Along with Engelsrud and Ek, she calls attention to the relational aspects of the body (Rosberg 2000). In her doctoral thesis *Body, Being and*

² My translation. "Kjærlighet og bevegelse. Fragmenter til forståelse av en fysioterapeutisk yrkesutøvelse"

*Meaning in a Perspective of Physiotherapy*³, she focuses the physiotherapist's understanding of the body and of the meanings of the physiotherapeutic treatment in rehabilitation.

Following her argument, the epistemological position sees meaning constantly produced in social interaction within a historical and socio-cultural context. Quoting Rosberg:

The understanding of the body as relation – as embodied life history and meaning – makes it possible to see the bodily treatment in physiotherapy as an opportunity to become aware of and to change the lived meaning in the embodied patterns of a person's being-in-the-world. [...] In conclusion, [her] research understands physiotherapy as much more than a treatment method. It develops the enriched view that it is a socially constructed process in which meaning is created from bodily experiences, owing to the patient being able to experience him/herself in new ways in the interplay with the physiotherapist. (Rosberg 2000:286,290. [] deleted/added)

Rosberg, as Ek and Engelsrud, underscores the centrality of interaction in physiotherapy. Their arguments suggest that viewing physiotherapy instrumentally, as application of methodical treatment, bereaves the patient from valuable insights and knowledge – which might impede the therapeutic outcome in the long run. These insights gained from studying primarily physiotherapists, are critical when inquiring into patients experiences. Rosberg states physiotherapy as a socially constructed process, an argument that lends support to appropriating sociological and critical hermeneutics in the present study. Her choice of the concept interplay points towards the to-and-fro movement in social interaction, which gives room for negotiating the situation at large.

... conceiving function

Thornquist's contribution to the body of knowledge in physiotherapy is considerable. In *Conceiving Function: An Investigation of the Epistemological Preconditions, Conceptualizations and Methodologies in Physiotherapy* (1998) she investigates

[...] [what] remains in the background in [Ek's and Engelsrud's] analysis: how therapists comprehend patients' health problems (i.e. how therapists examine, categorize, and understand patients). [She] is motivated by this choice of focus simply

³My translation. "Kropp, varande och mening i et sjukgymnastisk perspektiv"

by the fact that *what bring patients to physiotherapist in the first place are ailments and problems*. The physiotherapist is obliged as a professional to act in order to alleviate the ailments, help solve the problems, or at least attempt to inhibit deterioration of the situation. In short, the physiotherapist is compelled *to do something* with respect to the patient's pain and plight. (Thornquist 1998:12, emphasis in original, [] added)

Thornquist shows how the different strands of specialisation in physiotherapy – e.g. psychomotor physiotherapy and orthopaedic manipulative treatment – also bring with them special forms of interaction and conceptions of function (Kjølsrød & Thornquist 2004; Thornquist 2001; Thornquist 2006; Thornquist 1998). When inquiring into patient's experiences, the professional body's specialisation system has a direct bearing on the therapy situation – and henceforth will have a bearing on the experiences gained by the patient, Thornquist contends. These strands of specialisation are conspicuously gendered; women become psychomotor physiotherapists, men become manipulative therapists. Chapter two details gendered specialisation and work division within Norwegian physiotherapy, which can be read as a structural justification of Thornquist's arguments. Heed was paid to these insights when participants were recruited to this study. As far as possible, participants were recruited to represent the broad field of gendered physiotherapy practice.

... emotions

As shown in the section on massage, physiotherapy is inseparably tied to an ambiguous field of mixed emotions. Gunvor Gard and Amanda L. Gyllensten have studied physiotherapists working with psychiatric patients, and contend that emotional intelligence⁴ becomes increasingly important (Gard & Gyllensten 2004). The physiotherapists who participated in their study saw emotional aspects as important corollaries of good therapist–patient interaction. The therapist ought to identify and express own emotions, as well as identify emotions in patients and help them express their emotions. These authors arrive at the same conclusion as Thing (see below), acknowledging emotions as a prerequisite of positive

⁴ Gard and Gyllensten explains emotional intelligence as abilities in five domains: 1) knowing one's emotions, self-awareness – recognizing a feeling as it happens; 2) managing emotions so that they are appropriate, which is an ability that builds on self-awareness; 3) motivating oneself; 4) recognizing emotions in others; and 5) handling relationships, namely having skill in managing emotions in others (Salovey P, Mayer J 1990 *Emotional Intelligence*. Imagination, cognition and personality 9:185-211)

treatment outcomes. Their conclusions and recommendation have a bearing on my study, where emotions are inseparable from bodily concerns and human agency. The present study inquires into an ambiguous field of proximity. Following Gard & Gyllenstens's lead, the therapist's emotional intelligence may account for some of the experiences the participants have gained. This is not inquired into in the present study.

Weerakoon et al.'s study of perceived discomfort among allied health professional students in clinical situations with a sexual connotation identified a high level of discomfort (Weerakoon et al. 2004). Most of the students expected to feel high levels of discomfort when dealing with overt or covert sexual remarks, or when they were obliged to ask patients about their sexual practices, experiences and preferences to complete a case history. Weerakoon et al.'s findings suggested that men were more likely to anticipate feeling comfortable when having to deal with covert and overt sexual remarks, walking in on a client masturbating or dealing with a lesbian patient. Women were more likely to feel comfortable about dealing with a homosexual male or a 14-year-old girl seeking contraception (Weerakoon, Jones, Pynor, & Kilburn-Watt 2004). The students were treated as "homogeneous" allied health professionals, and hence it is not possible to detect a specific significance for physiotherapy. Furthermore, these findings reflect socially sanctioned everyday norms in Norway, and as such the contribution to knowledge may seem sparse. However, the importance of studies like this one, published in a journal of allied health, demonstrates how social institutions and cultural backdrops imprint any situation within any institutional or social frame – a vital point of reference for the present study.

Thing has done several studies in physiotherapy clinics, observing injured athletes and their therapist during rehabilitation periods (Thing 1999; 2001; 2005a; 2005b; 2006). She introduces the concept of bodily emotion regimes to designate the social rules that govern emotions in a therapeutic situation, and contends that emotions have an absent presence in physiotherapy, an argument in line with Gard & Gyllensten (2004). The hub of Thing's arguments is the body regimen instituted in physiotherapy clinics, which serves as a constraint on the athletes' emotions and recovery. The therapeutic system neglects the body as a living amalgam of physical, psychic and social dimensions. According to Thing, on the one hand, the neglect of emotions can be characterized as an unintended consequence of the fact that physiotherapy is anchored in medical science and the positivist mode of measuring

and organising and controlling the body. On the other hand, the phenomenon can also be explained in terms of the organization of work in the clinic, the way in which time is structured and the fact that treatment takes place in groups. Thing contends that the practice of physiotherapy needs to be reorganized, to give room for ‘private’ conversations and guidance, at least once in a while, where the personal and emotional aspects of both ailments and therapy can be dealt with. Thing’s findings lend extensive support to the studies presented above – where the arguments were extracted from the therapists’ point of view. Thing’s further work on body regimens in the physiotherapy clinic and sports related aggression will be employed later (Thing 1999; 2001; 2005a; 2005b; 2006).

... as well-being

This sub-section turns to well-being. Some core insights gained from the studies presented above, is the importance of social interaction in therapy, of personal agency, and an unresolved question of emotions and pleasure. Following Gadamer (1996), an etymological reflection upon frequently used concepts reveals that they carry sedimented experiences that still can be heard in everyday use – if we listen. In German and Norwegian, the etymological echoes of ‘treatment’ are easily heard – *behandlung* and *behandling* – doing something with the hands. Treatment is a handling of the Other, by means of one’s hands. The word *therapy* has its origins in the Greek *therapeia*, a phenomenon where it is impossible to separate handling from conversation – it is a dialogical relationship involving words and touch at once, where the therapist is at the Other’s ‘service’ (Gadamer 1996). The German (physio)therapy traditions have their tenets in the health resorts and spas – where *therapeia* is equated to wellbeing. These traditions encompass the ‘service’ and body-affirmative measures of massage, hydrotherapy, heat therapy, diet and exercises. According to the participants in this study, *therapeia* is highly valued and available on convalescence abroad.

In the early 1980s, this was not the kind of service common to the Norwegian or Scandinavian (physio)therapy traditions, nor with the demands of women’s liberation movements that emerged during the 1970s. Women at men’s service were construed as sexist exploitation and oppression of women. This ‘service’ was understood as a one-way delivery, to a patient that was a passive consumer of the women’s services for the sake of his own wellbeing. The conceptions were probably insensitive to alternative ways of interaction and

co-creation of therapy. The reluctance or anxiety to be at someone's service follows perceptions of massage as a dubious pleasure and undertaking, as noted above. Historical practices and events due to social inequality, and later social mobilisations as the women's liberation, imprint professional practice in subtle ways.

... as gendered research practice?

All the studies in this section are conducted by female scholars. The majority of physiotherapists in Scandinavia are women, and hence the majority of female scholars should not be conceived of as a surprise. However, scholarship attending to either relational aspects of physiotherapy, or efficacy or outcome of physiotherapy, may be read as a result of gendered work division and professional specialisation. Physiotherapists, as other researchers, follow their curiosity, and most often start their inquiries where they stand. The present study is no exception. However, the methodological issue of gendered research will be addressed in chapter four.

Critical hermeneutics, the interaction order and patients' experiences

This section introduces the analytical paradigm chosen for the present study. Chapter three will elaborate on the theoretical grounding more thoroughly. During the last decade, several scholars have turned to philosophy to advance an argument of a fruitful linking of hermeneutics and clinical practices (Paterson & Higgs 2005;Slattery, Krasny, & O'Malley 2007;Smith 2007;Svenaesus 2000b;Svenaesus 2003). Hermeneutics is advocated as a paradigm for clinical encounters, as well as an interpretive paradigm and fruitful research strategy within these practices. The hallmark of hermeneutics is the dialogue, which comes into play as the parties are attuned towards each other and the issue at stake (Gadamer 1993;Gadamer 1996). Following this, inquiring into and understanding bodily concerns – the reason for seeking therapy in the first place – evolves through dialogical and bodily interaction as a hermeneutic event of understanding. The studies referred to above all acknowledge the interaction and dialogue as such as a fruitful path to recuperative outcome on the patient's behalf.

Interaction and dialogue necessitates negotiations and creation of an understanding of the situation. Subsequently, when inquiring into patients' experiences the theoretical paradigm chosen must be able to uncover agency and conditions for interaction. The present study's interpretive frame is grounded in Gadamer's philosophical hermeneutics and Goffman's studies of the interaction order (Gadamer 2007; Goffman 1983). Following Kögler, interpretations in the human and social sciences are oriented at reconstructing intentional human agency, which expresses itself in linguistic or other purposive behaviour (Kögler 2005b). In other words, the interpretive paradigm of research aims at identifying resources that can be used to make new purposes possible. In the present context, the aim is to identify resources that can be appropriated for creating or sustaining a notion of health, well-being or recuperative physiotherapy, i.e. make new purposes possible. This study appropriates critical hermeneutics, which acknowledges that any interpretation or understanding is enabled or constrained by the symbolic, practical and subjective spheres of the agents' interpretive backgrounds. Goffman's understanding of social interaction is appropriated to detect and discuss the different aspects of the interactants interpretive backgrounds and purposive behaviour. This study is particularly concerned with the significances of gender. Gender is understood as a social institution, i.e. as a social phenomenon encompassing practice, conflict, identity, power and change, which has a significant impact on social order and social interaction (Martin 2004).

The empirical material for this study was created in four different groups of women and four different groups of men. Each group was invited to a group discussion with me and my research assistant to elucidate and elaborate on their experiences with physiotherapy and other related or relevant services. The participants, or rather my guests for a couple of hours, were introduced to the study in general and to gender as a social institution and hence a fruitful and critical frame for inquiring about the bodily interaction in physiotherapy. Grounding a study in critical hermeneutics implies a responsibility for the research context, which serves as an interpretive background for the moment. We sought to attend to the participants' well-being during the sessions, as well as making way for dialogical interactions. The conversations were relatively free, revolving around the hub of interaction, i.e. bodily and dialogical interaction and proximity, and figurative and real intimacy in treatment sessions. As a part of the discussions, I and the co-host/research assistant posed

critical questions and suggested interpretations as we went along. The participants are presented in chapter four, along with methodological considerations.

This study is grounded in an interpretive paradigm which aims at reconstructing intentional human agency. Following this strand lead me to introduce the participants' voices in most of the chapters in the thesis – even though their voices are specifically amplified from chapter five.

Thesis structure

Chapters one through four situate the inquiry, map Scandinavian physiotherapy and gendered work division in Norway, present the theoretical underpinning of the study, and detail methodological issues concerning group based research.

Chapters five through ten are presenting and discussing the empirical material. The participants identified several possibilities and constraints for recuperative encounters, as well as resources to make new purposes possible. For the sake of the argument, their main contributions are presented topic by topic, even though they are more or less inseparable in real life.

Chapter eleven is slightly different. It is partly a methodological consideration, and partly an offspring from the group discussions that prompted a new theoretical reflection. The groups discussions were immersed in laughter, as will be seen in the excerpts. Henceforth, I chose to include a chapter on laughter.

Chapter twelve is closing the thesis, outlines the argument and suggests new areas of future research.

Closing remarks

The aim of this study is to inquire into patients' experiences to gain knowledge about possibilities and constraints for recuperative encounters with physiotherapists. The study focuses on human agency, and seeks to learn what patients' do to reach these ends. The next chapter turns to Scandinavian physiotherapy in general, and more specifically to the Norwegian work division.

2. Scandinavian short (his)stories

Scandinavian physiotherapy is deeply indebted to the Swede Pehr Henrik Ling, as well as to spa traditions from southern Europe, medical knowledge, societal changes and epidemics (e.g. poliomyelitis in the 1950s). Not only does this heritage take several forms in Scandinavia, it seems to be the root of persistent conflicts, of gendered identity and work division. In the following, some maps of the historical and socio cultural backdrop of Norwegian physiotherapy are outlined to illustrate how the profession emerged. The body of knowledge presented is assembled from research and information provided by associations of physiotherapists. Additionally this chapter provides a definition of contemporary Norwegian physiotherapy.

To readers familiar with physiotherapy this chapter might stand as superfluous, detailing too much information. Physiotherapy is a complex phenomenon both scholarly, practically and structurally. Either way, this represents the context and interpretive backdrop for clinical encounters – and henceforth the boundaries for which resources one can easily or more cumbersome mobilise in therapy. For the purpose of this study, the history is presented as a gendered reading of the field.

Where is physiotherapy?

The heading of this section alludes to the fact that physiotherapists are applying their knowledge in a huge range of working areas – best illustrated by contextualising their diverse working areas. Physiotherapists are particularly knowledgeable about the body's muscular skeletal system, respiration (breathing) and circulation's (blood flow) impact on the person's ability to move around in coordination with the material and social surroundings. They also pay attention to how contextual influences impede bodily function. A common denominator is bodily concerns; whether they relate to how to increase running speed, reduce pain of any origin, enhance mobility, facilitate lung clearance or relate to health, security and environment in the working life. Commercial enterprises, management or human relations tasks, political or bureaucratic affiliations, teaching and research, all of which are additional locations for physiotherapists.

Bodily concerns can be ranged along three diverse continuums; from healthy to ill, from

acute injury to chronic ailments, from young to old. Further, the work division in physiotherapy creates two other continuums; private enterprises on the one side and public health care on the other, and a specific gendered work division and specialisation tendency. An apt description renders male physiotherapists in private sector, relating to young, healthy patients, suffering from acute but curable concerns. Female therapists relate to old patients with chronic illness within the frames of public health care. The impact of this heterogeneous terrain on the present study is further elaborated below, and in chapter four, where recruitment of participants are described and justified. The apt description of physiotherapy is nuanced throughout the chapter.

What is physiotherapy today?

This section is drawn from the Norwegian Physiotherapist Association, NPA, English website. The description was sanctioned by the NPA board in 2006. The complete downloaded citation is in the Appendices.

In Norway physiotherapy is protected by law⁵. Norwegian citizens are entitled to get treatment from a physiotherapist if they need it. Both title and functions are legally defined. The physiotherapist is legally responsible for his or her own professional actions. Physiotherapy constitutes prevention and treatment of disease and physical suffering. The physiotherapist has extensive knowledge of the parts of the body we use when we move i.e. muscles, tendons, joints, the circulatory system, and respiration. The main tasks of a physiotherapist are health promotion and disease prevention, treatment, training, and rehabilitation.

The physiotherapist knows why disease and injury occur, and can give advice on how to prevent pain and relapse of disease. The physiotherapist's work in health clinics, in nurseries, at schools and in work places is mainly preventive. A sub speciality within physiotherapy is ergonomics, which involves organising work environment. Many companies have their own physiotherapist who gives advice on how to promote health and to improve the environment and safety in the work place.

⁵ Statutes in force are listed in the Appendix

First the physiotherapist performs a thorough examination; the type of treatment given depends on the patient's resources and the connection between pain, joint mobilisation and muscle tension. Training, exercise, massage, hot and cold treatment or electrotherapy are among the types of treatment that can be given. The treatment is given either individually or in groups.

The training of children with congenital dysfunction to a best possible level of functionality is called habilitation. This is interdisciplinary work where the physiotherapist is part of a habilitation team. Such teams are found in every region of the country. Habilitation takes place in the counties, at the hospitals and in special institutions. Rehabilitation is aimed at helping persons with handicaps or chronic disease so they can manage on their own and function socially. The aim of this process is for the patient to regain or preserve a best possible level of functionality through learning and by using own resources. The term rehabilitation is used about the work with patients from 16-18 years of age to the end of life. The patients may have been subject to accidents or disease. One such disease may be stroke, which is an example of a disease that demands interdisciplinary co-operation. Physiotherapists work with rehabilitation in the patient's home, in nursing homes, and in special institutions.

Many Norwegian physiotherapists have postgraduate training. The most common fields are manual therapy and psychiatric and psychosomatic physiotherapy. Physiotherapists who have been trained in manual therapy have special competence on neck, back and pelvic disorders. Following a thorough evaluation, the main elements in the treatment approach are patient guidance, joint manipulation or mobilization, and exercise therapy. Psychiatric and psychosomatic physiotherapy aims at easing physical tension, improving respiration, or body awareness. This kind of treatment is not only aimed at treating local symptoms, but is a continuous treatment. Many physiotherapist offer group treatment in psychiatric and psychosomatic physiotherapy.

The World Confederation for Physical Therapy, WCPT, formulated a position statement of

physical therapy in 1999.⁶ While it largely rings true with Norwegian education policy, the training of physiotherapists at all five Norwegian university colleges adheres to the national curriculum laid down by the government.⁷ This national curriculum can be adapted to local needs and conditions, which may differ from place to place. The Mensendieck programme at Oslo University College centres on gymnastics and functional exercises. The Mensendieck system sees human beings in a dialogical interchange with their surroundings, influenced by, and influencing themselves in turn internal and external forces. Through action (gymnastics, exercises), bodily experience and reflection, patient and therapist can gain insight. The other four programmes take as their point of departure the body and its movement, the theoretical platform comprising natural science, movement science, and medical science. The University College at Tromsø clearly states that the body is influenced by emotions and living conditions, social and cultural factors, diseases and injuries. The other programmes reference socio cultural factors as well, but more or less vaguely. The differences are relatively minor, as textual representations.

All five programmes are concerned with the physical activity of the patients, and their determination and ability to take responsibility for their own health. The gymnastic tradition is evident in the Mensendieck programme, and is implicit in the terms “physical activity” and “responsibility” found in the other programmes. All five emphasise patient responsibility, and the curative potential of movement, analogous to Ling’s ‘moral’ gymnastics (Ljunggren 1999; Ottoson 2005). The position statements formulated by the Norwegian Physiotherapists Association (NPA), cited in the section above do not mention patient responsibility, movement therapy, physical activity or participation on behalf of the help seeking party. The description is conspicuously positioning the physiotherapist as the sole knower and actor – as opposed to contemporary ideas of participation and partnership in patient-provider relations (Martinussen 2008). Next chapter will elaborate on Ling’s gymnastics, and complicate the background and contemporary landscape of Norwegian physiotherapy further.

⁶ Position statement Description of Physical Therapy, WCPT, approved May 1999, see Appendix.

⁷ Rammeplan og forskrift for 3-årig fysioterapeututdanning fastsatt av Kirke-, utdannings- og forskningsdepartementet 16. desember 1997, revidert og 1. desember 2005 av Forsknings- og utdanningsdepartementet.

Physiotherapists can establish and run fitness studios, gyms and suchlike, as well as establish clinics. Operating subsidy is politically allocated to selected clinics⁸. While general physiotherapists can receive patients for assessment without referral from a doctor, to get a refund from the national insurance authority, patients need to be referred. Manual therapist, however, may receive patients and refund without referral from a doctor.

Reading *textual* definitions of physiotherapy published by the colleges, NPA and WCPT on the Internet, it appears that professional autonomy and patient's disorder enjoy privileged positions, followed by movement and physical activity. Physiotherapy is still a young profession, and autonomy is not taken for granted. The patient-therapist relationship and the conception of the individual patient still need to be worked out – at least according the participants in this study, and several scholars which will be introduced in this chapter. Citing independent movement as a health signifier, and interaction as a condition of successful treatment, touches on the social and cultural disciplining of the body and the problem of patient compliance, and renders the therapist as the supreme knower. This description is by no means anchored in a hermeneutic ontology of physiotherapy.

Sweden: A long-lasting homosocial conflict with tremendous impact

The Swedish historian Anders Ottoson has studied the history of Swedish physiotherapy as a masculinisation and de-masculinisation of the profession, 1813-1934, and a parallel re-gendering of the physiotherapist from male to female practitioner (Ottoson 2004; Ottoson 2005). In the nineteenth century physiotherapy was a scientific and governmentally sanctioned medical treatment assumed to be of benefit to almost every illness. During most of the nineteenth century, being a physiotherapist was synonymous with being a nobleman or member of the upper bourgeoisie and officer in the Swedish army. These men had been trained at KGI, Kungliga Gymnastiska Centralinstitutet.⁹ KGI was founded in 1813 by Pehr Henrik Ling, the father of gymnastics. The students were trained in pedagogical gymnastics (school gymnastics, physical education), military gymnastics (mostly fencing), and

⁸ Operating subsidy (driftstilskudd) is allocated politically. This is a means of stimulating physiotherapist (and physicians and psychologists) to establish clinics outside the major cities, and prevent surplus services in urban areas, and scarce services in rural areas. Refunds follows political priorities as well.

⁹ The Royal Institute of Gymnastics, now Stockholm University College of Physical Education and Sport

physiotherapy (medical gymnastics). Women were admitted in 1864, with few objections, but remained a minority until the turn of the century. After three years' training the students earned the title "gymnast director."

Ottoson (2005:384) remarks that physiotherapy is one of Sweden's most successful cultural exports. The gymnast directors, strengthened by government-endorsed education and a conviction that physiotherapy was a universal restorative, travelled worldwide to spread their scientifically based treatments. Clinics were established in major European cities and at the seaside, and at health resorts. Ottoson describes the accomplishments of these male physiotherapists as 'tremendous', and they gained world fame. However, such a triumph has a darker side. The orthopaedists at Karolinska Institutet (KI, Carolingian Institute) argued with the physiotherapists over who was best fitted to diagnose and cure illness by means of physiotherapy. None of them disputed the effect of physiotherapy. This battle, which lasted for almost 80 years, was frequently fierce and combative when it touched on who should have priority of interpretation in the medical field. The orthopaedists finally prevailed, and physiotherapist were subdued and brought under tolerable medical regulation. Anders Ottoson remarks that this is partly erased from history, which of course is always is written by the conqueror. The fact that the physiotherapists for a long period held the right of interpretation, is erased from our historical consciousness, or was, until Ottoson's study recovered it (Ottoson 2005).

Ottoson interprets the conflict between the physicians and physiotherapists as a homosocial conflict, and follows the regendering of the profession in a governmental investigation from 1929 which recommended that men should not be allowed to become physiotherapists – an educational obstacle raised for men, while dismantling almost all educational obstacles to women (Ottoson 2004;Ottoson 2005). Even though these recommendations were never legalized, in practice they came more or less to shape developments. The 1934 curriculum at KGI was revised to make it less attractive to men; admission requirements were cut, all claims to science were removed, and the entire course was reduced to one year. Ottoson coins a new concept for this transformation, de-masculinisation, showing what men do to other men, rather than focusing on what men do to women. He claims that the regendering of the profession started long before women made their presence felt. The fight concerned entitlement to masculine attributes – control, autonomy, science, upper-class social position. According to Ottoson, around 1930, there was not enough masculine room left in the medical

field to accommodate male physiotherapists with scientific credibility. Thus, they abandoned the profession. The feminisation of the physiotherapy profession was completed after nearly 80 years of struggle (Ottoson 2004;Ottoson 2005).

The works of two other Swedish historians (Lindroth 2004;Ljunggren 1999) laid foundations for the work of Ottoson, and are extensively cited in his doctoral thesis. Lindroth primarily analysed the Ling gymnastics, while Ljunggren studied embodiment of masculinity in Ling gymnastics. Their studies make exciting reading, but Ottoson's arguments capture the main issues when it comes to historical tenets of physiotherapy, and the purpose of this study.

To my knowledge, analysing professional development in Scandinavian physiotherapy by theorizing masculinity was first advanced by Birgitta Bergman in her doctoral thesis *Being a Physiotherapist* (Bergman 1989). She notes how increasing numbers of female physiotherapists use the same professional strategies as men in their careers. According to Bergman, an internal division of labour between the sexes is evident in physiotherapy as well. Women are more patient-oriented, less interested in techniques and work for longer-term goals. Male physiotherapists are found in less hierarchical and patriarchal organisations than female physiotherapists. Generally men have higher salaries, even if they do not advance to managerial positions (Bergman & Marklund 1989). Dahle notes that in the late 1980s the Norwegian physiotherapy profession are about to become more masculine (Dahle 1990:277).

Norway: An apprentice to Sweden

The first Norwegian physiotherapy school was founded in 1897. Journalist Karin H. Haugen has written the history of the first 100 years of physiotherapy education, in connection with the centenary in 1997 (Haugen 1997).

The story of Norwegian physiotherapy starts in Sweden and with the establishment of three private schools in Christiania (now Oslo) at the beginning of the last century. The first Norwegian physiotherapist (a man) graduated from KGI in 1841. Several other men followed in his footsteps. The first two Norwegian women graduated from KGI in 1877. Until the opening of a Norwegian educational facility in 1897, 13 Norwegian men (officers) and 14 women had graduated from the three-year study at KGI.

Three Norwegian physicians (one of them a former medical gymnast) founded Christiania Orthopaedic Institute, COI, in Christiania in 1897, which was to be the first Norwegian institute to provide training for medical gymnasts/physiotherapists. The school offered a one-year course and three women made up the first class. In 1897, only women were allowed to enrol. Two years later the school changed its name to Christiania Orthopaedic and Medico Mechanical Institute, COMMI. Physical education (health gymnastics as opposed to medical gymnastics) was added to the curriculum at the same time. A few male applicants were enrolled between 1900 and 1911, but there were fewer than twenty of them compared to approximately 250 female students. There is sparse information about this, according to (Haugen 1997:89-91), other than that by 1911, male students were recommended to apply Norwegian School of Gymnastics for enrolment in physical education programmes. Ottoson's historical study of Swedish physiotherapy was not even started when Haugen wrote her book. Looking back at the homosocial conflicts outlined by Ottoson (2004;2005), and the recommendation to make physiotherapy a female occupation in Sweden, it is hard not to see developments in Norway in light of the Swedish conflicts. By 1946, however, COMMI was admitting male students, probably in response to a need after World War II to give students from Dr Arboe's Institute an opportunity to finish their education (see below). From 1946 to 1973 additional admission requirements in physical education/sport applied to the male students, often gained by attending courses at the Norwegian School of Gymnastics.

A second school was established in Christiania in 1926. This was the above-mentioned Dr. Arboe's Institute. This was a private undertaking established as a school for male students, but later on both male and female students were admitted. In contrast to the other schools, Dr. Arboe's offered part-time courses free of charge, if the students agreed to work unpaid-for at the clinic. According to Dahle, this was probably a predominantly a male career path, and a possibility for social leverage for male and female students from lower social classes (Dahle 1990:85 , n2). Dr. Arboe's Institute was closed following World War II, allegedly due to the principal's Nazi sympathies.

In 1927, the third school, Norwegian Mensendieck School, was founded in Oslo. Only female students were admitted until 1970. Students won the right to the title of physiotherapist in 1974, after the programme was expanded to include both massage techniques and electrotherapy. The Mensendieck system is especially devoted to the aesthetic dimensions of movement, and practiced nude exercising and training well into the second half of the

twentieth century. Training of self-consciousness, self-reflexivity and conscious body perception is vital in order to “model the body” according to the Mensendieck philosophy (Haugen 1997).

From the very beginning, only the upper-classes could afford to educate their daughters as physiotherapists. The female medical gymnasts were dependent on financial support (savings, inheritance) after they finished their education due to extremely low wages, and probably class and gender-related problems connected to pricing their services. They were at the service of the needy. According to Dahle (1990) and Haugen (1997), the male graduates earned their living in the military, combined with a military career.

COMMI was a private school until 1967, when it became a state-run school of physiotherapy. As a result, school fees were dropped. The Norwegian Mensendieck School in physiotherapy was private until 1979, when the state took over. Physiotherapy education in Norway has remained at a post-graduate level since 1956. In 1981 the schools became part of the university college system in Norway, and physiotherapists were admitted to some Master’s programmes.

Today, there are five university colleges that train physiotherapists in Norway, all state-funded and run, and free of charge.¹⁰ In 1995, admission to Bachelor’s degree programmes in physiotherapy started to be coordinated at the national level, and the national study programme of 1997 became mandatory.¹¹ It is also the case that male students frequently complete a physical education programme during or in combination with compulsory military service, at a college of sport, the Norwegian School of Sport Sciences and/or pursue careers in sports before studying physiotherapy. At the University of Bergen, a generic Master’s programme in physiotherapy was established in 1991, and a clinical Master’s in orthopaedic manipulative therapy in 2001. At the University of Tromsø a clinical Master’s programme in neurological physiotherapy was established in 2007. Today, several inter- and multidisciplinary Master’s programmes of interest to physiotherapists are offered at universities and university colleges.

¹⁰ COI, Christiania 1897, Mensendieck, Christiania 1927, Bergen 1976, Tromsø 1989, Trondheim 1992

¹¹ Rammeplan for fysioterapiutdanning av 16. desember 1997, Kirke- og undervisningsdepartementet. (National Study Programme in Physiotherapy, Ministry of Education). Revised 1 July 2004 and 1 December 2005 by The Department of education and research

Denmark: Influences from North and South

Schrivér's doctoral thesis on *Physiotherapy and Learning* briefly sketches the history of Danish physiotherapy (Schrivér 2003). According to her, an historical view is important to understand contemporary physiotherapy. Schrivér's argument is that the effects on physiotherapy of social and societal evolution best can be interpreted from a political vantage point. The primary roots of Danish physiotherapy are found in Switzerland, back in the sixteenth century, where medical doctors were trained in physiotherapy. Later, input from Sweden, Norway, Holland and Germany helped mould what became Danish physiotherapy. Schrivér counts several other roots. Ling's gymnastics is one of them. The others are bath traditions in Germany, thermo and hydrotherapy, where wellbeing and comfort were the aims. Massage, introduced in Denmark by a Dutch doctor, was established as a part of the profession's toolbox when the medical profession relinquished responsibility for physiotherapy. Accordingly, at the turn of the last century both medically informed massage and gymnastics were influential. However, Schrivér argues (Schrivér 2003), while health gymnastics prevails abroad, in Denmark physiotherapy rests on a medicine tradition, thanks to which physiotherapists are tacitly recognized as having the most knowledge about the patient's body, and entitled to make clinical decisions without involving the patients in any substantial manner. Schrivér's work challenges this, she argues, by building an alternative philosophy of physiotherapy.

Work division, conflicts, power, and identity – and gender

Embedded in the field of physiotherapy are stories and facts about work division, conflicts, power and identity – related to gender. Some of these are presented below, departing from scholarly work on the matter. As an illustration of contemporary challenges, a new area of political controversy facing the professional organisations is briefly presented.

Conflicts and numbers talking out loud

Norwegian physiotherapists have three different associations, two of them “offshoots” of the largest. Controversy in the beginning of the Eighties over a new law for local health services inspired the first split.¹² At the turn of the new century a dissent concerning orthopaedic

¹² Act no. 62 of 19 November 1982 relating to the municipal health services, in force from 1 April 1984.

manual therapists' quest to achieve legal recognition as a protected speciality, brought the third association into being.

The 1984 law required local authorities to provide a physiotherapeutic service, and it had an immense impact on the conditions and terms under which private physiotherapy practices could operate, e.g., working hours, agreements and contracts, assignments, funding/refunding. The same regulations applied to physicians in private practice as well. About one fifth of the membership - 1,000 physiotherapists (mostly men) - broke with Norwegian Physiotherapist Association (Norske fysioterapeuters forbund, NFF), to found the Private Physiotherapist Association (Private fysioterapeuters forbund, PFF, 1983). The aim of PFF was (and is) to promote physiotherapy as a liberal profession with access to unconditional public funds. After initially losing most of its members, PFF revitalized. According to the board, PFF have approximately 600 members, of whom 60 per cent are men.¹³ The third association, Norwegian Manual Therapy Association (Norsk manuellterapeutforening, NMF) was founded in March 2006, after years of conflict concerning professional independence and licensing of manual therapists (orthopaedic manipulative therapy). According to their Internet page, NMF have approximately 150 members, or more than half of the members of the subgroup of manual therapists in NFF, and half of the manual therapist in Norway.¹⁴

NFF has 8,350 members (25 per cent men, 769 students), and the working members are divided relatively equally between private and public services.¹⁵ Male members of NFF predominantly specialise in the areas of orthopaedic manual therapy (PFF and NMF members' only speciality), sports and ergonomics (health, security, and environment). Female NFF members predominantly specialise in the areas of psychomotor physiotherapy, children and general physiotherapy/family practice. As a consequence of this labour division, and boosted by women in part-time jobs in the public sector, male physiotherapists, as a group level, enjoy considerably higher wages and earnings. In short, female physiotherapists work part or full time in public sector, attend to people with chronic diseases, psychiatric disorders, geriatrics or children, have moderate wages and are subject to medical decision structures in hospitals. Male physiotherapists work full time in private sector, attend to people

¹³ Personal communication, 2005

¹⁴ <http://www.manuellterapeutene.org> Retrieved 10 June 2006

¹⁵ Fact about physiotherapy and NFF 2005-2007. Numbers from January 2005. The NMF-group members are included.

with acute diseases, orthopaedic problems or sport induced injuries, middle-aged patients, and enjoy a relatively free decision structure. As stated above, Enger (2001:16-22) saw this as creating 'considerate, patient women and effective, impatient men'. The gendered work division is almost the same as before the Municipal Health Services Act was put in force (Dahle 1984a;Dahle 1990;Dahle & Vannes 1985;Enger 2001).

In January 2005, there were more than 9,000 physiotherapists in Norway, irrespective of organisation membership, and not including students. When these numbers are recalculated in terms of labour input, we find twice as many physiotherapists in the private sector as the public sector, and one and a half as many in private sector if hospitals are included. A gendered re-reading suggests that women, as a majority, make up the public work force, and men, as a majority, the private work force in physiotherapy.¹⁶

New homosocial / heterosocial conflicts

Norwegian physiotherapists gained official authorization in 1936, by the Act of 19 June 1936 relating to medical gymnasts and masseurs. Before this, there had been several disputes with The Norwegian Medical Association (Den norske lægeforening, DNLF) and The Medical Faculty at University of Christiania (Haugen 1997;Kjølsrød & Thornquist 2004). Two of the major areas of conflict were the establishment of a school for medical gymnastics and the official authorization of the medical gymnast profession. At first, DNLF was against the establishment of the first Norwegian education program in medical gymnastics as an independent education program. They regarded medical gymnastics as a part of their professional knowledge and occupation. This is a blue print of the conflict in Sweden. The second controversy related to the authorization of these medical gymnasts. In the beginning of the twentieth century the female medical gymnasts in Christiania (now Oslo) had a hard time making the difference between themselves and the masseuses (often prostitutes) publicly known and accepted. They asked DNLF to support their petition for official authorisation, but DNLF refused. Political support for authorisation was withdrawn after DNLF came out against authorisation. Ultimately, authorisation was obtained, since the police needed a means to distinguish medical gymnastics from prostitution, or "dirty traffic" as it was labelled (Haugen 1997).

¹⁶ Statistics Norway. www.ssb.no/emner/03/02/helsetjko/tab-2005-12-02-13.html Retrieved 29 Mars 2006

A recently published paper is discussing the issue of physiotherapy and massage in UK (Nicholls & Cheek 2006). Little has been written about the profession of physiotherapy as a profession, they argue, and there are no critical accounts of the events surrounding the emergence of the physiotherapy profession in Western healthcare. Interesting though, to my study, are the parallel processes of women's entrance into paid work, and the broader questions of sexual morality at the time. At the beginning of the twentieth century, in UK and in Norway, massage scandals made it difficult to publicly distinguish between massage as health care and massage as prostitution. The masseuses' Societies were founded in response to these challenges, the education was regulated, and they worked hard to get legislation.

Physiotherapists in Norway were legally recognized and working time was regulated in law long before many other health professionals. Indeed, the 36 hour week remains to be achieved. However, the social memory of blurred boundaries between masseuses and medical gymnasts (physiotherapist) lives on (Dahle 1996;Dahle 1997).

Historically, male medical doctors opposed female students in medicine, they opposed a school for medical gymnasts, they opposed authorisation. Today, DNLF opposed the changes in the referral systems inherent in the Health Personnel Act (see below) which gave physiotherapists the right to treat patients and obtain a refund from the national insurance authority without a referral from a doctor. DNLF also opposed a pilot scheme allowing orthopaedic manual therapists and chiropractors to act as first line practitioners, diagnose problems and initiate treatment and give patients sick notes up to eight weeks (for employment). This scheme has been positively evaluated in terms of reduced levels of sick leave, speedier return to work, and hence saving government spending on sickness allowances and employers' spending on sick pay. As of 1 January 2006 chiropractors and (orthopaedic) manual therapist are allowed to receive patients for treatment, refer patients for x-ray examinations and to specialists, and issue sick-notes.¹⁷

Following Ottoson (2005), homosocial conflicts between male physiotherapists and male physicians eventually led to regendering the profession of physiotherapy in Sweden. Some elements of the conflict drifted from Sweden to Norway. The controversy concerning the

¹⁷ Ny ordning fra 1.januar 2006. Større valgfrihet for deg med muskel- og skjelettplager. Trygdeetaten desember 2005. <http://www.trygdeetaten.no/generelt/skjema/blanketter/IA08-0720bm09-2003.pdf>, http://www.trygdeetaten.no/sykdom/pdf/infoark_kiropraktor.pdf . Retrived 26 June 2006.

(male) manual therapists is both homosocial (a masculine dominated DNLF), and heterosocial (a majority of female physiotherapists in NFF). Today, as 150 years ago, everybody agrees about the therapeutic effect of manipulative therapy, but there is considerable disagreement about legislation, management, referral and national insurance remuneration schemes.

Closing remarks

This chapter has presented the tenets of Norwegian physiotherapy, and shown how the broad dimensions of athletics, care and gender are intertwined, and how this emerges as gendered specialisation and work division today. Few, if any of the participants in this study knew the profession's history, or had any detailed knowledge about the significances of gender. Most of them held the profession to be predominately male, and believed most physiotherapists worked in private clinics or at sports grounds. The present study has not inquired into these understandings explicitly. However, these statements make up part of the context for a clinical encounter.

The next chapter turns to the theoretical underpinning of the study.

3. Critical hermeneutics and the sociology of everyday life

This chapter presents the theoretical underpinning of the study; Gadamer's philosophical hermeneutics in its critical extension and Goffman's studies of self presentation and the social interaction order. The ontological premise of this study states every human being as intentional. Intentional expressions are described as agency, as the condition of being in action, and the means or mode of acting, building on understanding of the situation at hand. The chapter is divided into three subsections dealing with critical hermeneutics, the sociology of everyday life, and play and small behaviours, respectively. Feminist resources are identified in both scholars' work, and the theoretical relevance of gender is outlined. The last subsection ties Gadamer and Goffman together, coining play as a pivotal phenomenon and theoretical hub of the study.

Critical hermeneutics

Several scholars have re-read Gadamer in light of critical theory, deconstruction, philosophy of play or medicine (Code 2003a; Dostal 2002; Kögler 1999; Steinsholt 2001; Svenaeus 2003), and the horizon of hermeneutics, so to speak, changes in the reading. All forward an argument that the constellation of different paradigms strengthens philosophical hermeneutics – and broadens its relevance – particularly as critical hermeneutics. However, the critical potential has been available since long. Following Kögler, the Heideggerian double-edged conception of intentional agency (as dependent on an enabling and power-infected background) has re-emerged in contemporary social theory under the label of critical hermeneutics (Kögler 2006:207). Advocates of marginalised subjects arrive at critical hermeneutics by way of re-reading Gadamer in light of post-structuralist and postmodern thinkers (Code 1991; Code 2003a; Fiumara 2003; Kögler 1999; Kögler 2006; Pappas & Cowling 2003).

Common themes among feminist scholars have been to call attention to a philosophical silence regarding the material conditions for being, understanding and knowledge. As introduced in chapter one, interpreters are situated subjects dependent on their enabling and constraining backgrounds. Understanding is always directed at some object or issue, henceforth knowledge is always materially mediated through the interpreters' bodies and the issue at hand. The subject matter in the present study is obviously enacted and engendered

through bodies, as is the knowledge derived there from. The argument on materiality, however, is equally relevant where the body is silent or forgotten. All understanding is materially mediated, always. The next subsection discusses some of Gadamer's concepts and their critics in a feminist perspective.

Feminist resources in Gadamer

The research-question 'What do patients do to negotiate enabling and constraining aspects of therapeutic encounters, with particular reference to gender?' calls gender sensitive interpretations of Gadamer to the fore. The collected volume *Feminist interpretations of Hans-Georg Gadamer* (Code 2003) forward both the problematic and the promising by appropriating Gadamer's hermeneutics in gender studies and in studies of marginalised or oppressed groups of people. The issues of change, play, and listening are elaborated by several contributors, issues that are central to understanding interaction and agency in physiotherapy.

Gadamer's opus magnum *Truth and Method (TM)* was published in Germany in 1960. Not until fifteen years later was the first English edition available (TM 1975). Unfortunately (for Gadamer's reception), this English edition was released as Foucault and Derrida entered the international stage, apparently posing a more radical critique of contemporary positivist philosophy and science. The second revised English edition of *Truth and Method*, which came in 1989, eventually made Gadamer accessible to a wider Anglophone audience, and cleared up misunderstandings that the first translation and reception had created. The bibliography on Gadamer is enormous, but this subsection only deals with a few selected interpretations of his philosophical hermeneutics – primarily his masterwork. I will return to his later writings in the empirical chapters.

Lorraine Code's introductory essay 'Why feminists do not read Gadamer' (2003b) illustrates the situatedness and material mediation of knowledge. She tells of Gadamer who was known as a patriarchal Christian conservative, an elitist thinker of the privileged classes. His relentless insisting on tradition and historicity in his philosophical hermeneutics, and his alleged failure to address uneven distribution of power and privilege, are all issues that are incommensurable with feminist thinking, Code contends. For some, this outweighs Gadamer's innovations and contributions that should have a ring to feminists. Below, Code

gives reason for why she, and others, read and should read Gadamer:

Gadamerian hermeneutics – in which knowing is engaged, situated, dialogic, and historically conscious – has much to offer to feminists and other theorists of subjectivity, agency, history, and knowledge who are disillusioned with an empiricist-positivist legacy that manifests itself in epistemologies of mastery and domination, with an operative conception of objectivity that requires dislocated, interchangeable knowers who stand as distant, disinterested spectators of the object of knowledge. [...] Gadamer proposes hermeneutics as an interpretive, historically conscious practice of working to achieve understanding. [...] [H]ermeneutic understanding is multifaceted, complex, richly textured: it varies not just quantitatively but qualitatively in its reciprocal relations among interpreters, texts and ideas. Both historically conscious and reflexively conscious of its own historicity, it is achieved dialogically, in conversations between the “fore-knowledge” that comprises the “horizon” from which an interpreter enters an encounter, and the texts, events, works of art, other people that are equivalently historical. (Code 2003b:4)

Gadamer’s main argument and most cited sentence from *Truth and Method* is quite appealing in its simplicity: Being that can be understood is language (Gadamer 2006d:470). To Gadamer, language is something more and something else than mere talk and communication, and he took great pains and a lifetime to elaborate on all aspects of understanding and language (Gadamer 2007). Conversations were his starting point, often exemplified by ‘... certain kinds of conversations between doctor and patient’ (Gadamer 1996). Code, referring to Malterud’s work (Malterud 1992; Malterud 1993; Malterud 1995), elaborates on the medical encounter to demonstrate how the medical meeting embed an interpretive openness, honouring both the patient’s and the physician’s views through dialogic negotiations (Code 2003b:29).

Code contends that some feminists (and others) have confused “fusion of horizons” with coherence. For some, fusion of horizons are understood as mutual understanding of the issue at stake, for others, this concept signals appropriation and merging in which separate identities and points of views are subsumed, often to the disadvantage of less privileged participants (Code 2003b:5). This latter argument is understandable in the light of Kögler’s reminder of the power-infected interpretive background. A more generous reading of Gadamer might demonstrate that his concept of fusion of horizons may have been misinterpreted, as Code suggests. Gadamer explains:

Consciousness of being affected by history is primarily consciousness of the hermeneutical *situation*. To acquire an awareness of a situation is, however, always a task of peculiar difficulty. The very idea of a situation means that we are not standing

outside it and hence are unable to have any objective knowledge of it. We always find ourselves within a situation, and throwing light on it is a task that is never entirely finished. This is also true for the hermeneutic situation – i.e., the situation in which we find ourselves with regard to the tradition we try to understand. (...) *To be historically means that knowledge of oneself can never be complete.* All self-knowledge arises from what is historically pregiven, what with Hegel we call “substance,” because it underlies all subjective intentions and actions, and hence prescribes and limits every possibility for understanding any tradition what so ever in its historically alterity. (...) Every finite present has its limitations. We define the concept of ‘situation’ by saying that it represents a standpoint that limits the possibility of vision. Hence essential to the concept of situation, is the concept of “horizon.” The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons, and so forth. (TM 2006:301), emphasis in original)

The citation above demonstrates some of the virtues of feminist knowing listed by Code; engaged, situated, dialogic, and historically conscious understanding. The Gadamerian horizon is cognate to contemporary understandings of situatedness; everything is seen from a particular vantage point. “To be situated within a tradition does not limit the freedom of knowledge but makes it possible” (TM 2006:354). Below Gadamer’s elaborates on the necessity of prejudices for understanding, another concept that has a bad ring to his critiques:

In fact the horizon of the present is continually in the process of being formed because we are continually having to test all our prejudices. An important part of this testing occurs in encountering the past and in understanding the tradition from which we come. Hence the horizon of the present cannot be formed without the past. There is no more an isolated horizon of the present in itself than there are historical horizons which have to be acquired. *Rather, understanding is always the fusion of these horizons supposedly existing by themselves.* We are familiar with the power of this kind of fusion chiefly from earlier times and their naiveté about themselves and their heritage. In a tradition this process of fusion is continually going on, for the old and new are always combining into something of living value, without either being explicitly foregrounded from the other. (TM 2006:305, emphasis and quotation marks in original)

Feminism, more often than not, are associated with women’s studies or women’s emancipation movements. Feminism, in these readings of Gadamer is not particularly concerned with issues related to women, but with disadvantaged people more generally. Social agency and change are hence key issues. Hekman (2003) argues that on the key issue of change, Gadamer’s hermeneutics offers a clear strategy, by way of his construal of prejudice as condition for understanding. Gadamer claims that prejudices can be revealed and examined. When we gain new experiences, this is a confrontation; it sets something new against something old. According to Hekman, the constant juxtaposition of tradition and new

experience, understood in the context of the historical situatedness of all understanding, provides Gadamer's hermeneutics with its critical possibility (Hekman 2003:193). Gadamer's 'ontology of change', reveals that presupposing the situatedness of knowledge does not preclude, but rather necessitates critique.

Another key issue with feminism is the construal and conception of the Other as different from self. Alcoff lists four central features of Gadamer's philosophical hermeneutics that are particularly useful for feminists (Alcoff 2003:232); i) openness to alterity, ii) the move from knowing to understanding, iii) holism in justification, and iv) immanent realism. These four features build her Gadamerian feminist epistemology. Openness towards alterity, the ability to acknowledge the Other whether in therapeutic situations or in research groups, are central to this study, as is Alcoff's highlighting of Gadamer's insistence that understanding is not a method, it is an event. In her reading, Gadamer develops a plurality of types of knowing, and he emphasises the play of movement without closure that characterises understanding (ibid:232).

Alcoff furthers this argument. Openness is not about a loss of self or a denial of one's own critical consciousness. It is rather to be addressed by the Other, whether a text or a person, and be open towards the questions posed to one's own fore-meanings and prejudices by the Other's alterity. If the interpretation is successful, the self is changed in the process (Alcoff 2003:236). As Gadamer explains:

Openness always includes our situating the other meaning in relation to the whole of our meanings or ourselves in relation to it. (...) *The hermeneutic task becomes of itself a questioning of things* and is always in part so defined. This places hermeneutical work on a firm basis. A person trying to understand something will not resign himself from the start to relying on his own accidental fore-meanings, ignoring as consistently and stubbornly as possible the actual meaning of the text until the latter becomes so persistently audible that it breaks through what the interpreter imagines it to be. Rather, as person trying to understand a text is prepared for it to tell him something. That is why a hermeneutically trained consciousness must be, from the start, sensitive to the text's alterity. But this kind of sensitivity involves neither "neutrality" with respect to the content nor the extinction of one's self, but the foregrounding and appropriation of one's own fore-meanings and prejudices. The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings. (TM 2006:271-2, emphasis and quotation marks in original)

For Gadamer, understanding is built on a common ground, otherwise a dialogue is impossible.

To conduct a dialog requires first of all that the partners do not talk at cross purposes. Hence it is necessarily has the structure of question and answer. (...) For as we have seen that to question means to lay open, to place in the open. As against the fixity of opinions, questions make the object and all its possibilities fluid" (TM 2006:360)

Alcoff interprets this as a counsel to a kind of listening that holds one's own views in abeyance long enough to hear a possible 'truth'. It is a counsel to lay down one's epistemic guard she ends (2003:239). Establishing a common ground for therapy presupposes reciprocal curiosity and aesthetic attention, as the first step towards dialogical interaction. As the empirical chapters will demonstrate, attentive listening is a key issue in establishing a common ground and a situational definition.

To summarise this subsection, feminist readers who embrace Gadamer's hermeneutics are emphatic to show how knowing is engaged, situated, dialogic, and historically conscious, and that hermeneutics has much to offer. Understanding is not a method, its and event where we continually have to test all our prejudices and fore-knowledge. 'Understanding is in fact only possible when one bring one's own presuppositions into play!' (Gadamer 2007:62) Gadamer emphasises the play of movement without closure that characterises understanding, and the possible expansion of horizons and the opening up of new horizons. If the interpretation is successful, the self is changed in the process. As Gadamer explains 'The hermeneutic task becomes of itself a questioning of things' (TM 2006:271) and further 'The real power of hermeneutical consciousness is our ability to see what is questionable' (Gadamer 2007:85). The interplay of questions and answers bring the issues at stake into the open, which makes possible to reconstruct human agency.

As shown above, feminist critics have relentlessly called attention to Gadamer's conspicuously disembodied hermeneutics; a paradox given his phenomenological position and the influences of Maurice Merleau Ponty's *The phenomenology of perception*, published in French in 1945. Merleau Ponty (1908-61) was inspired by Husserl (1859-1938) and Heidegger (1889-1976), as was Gadamer. They were contemporaries. Gadamer's re-definition of language and understanding, and his turn to practical philosophy, *phronesis*, and

later the enigma of health, may shed some light on these matters – why the body apparently is forgotten. The empirical chapters will return to Gadamer’s forgetting of the body several times.

Towards critical hermeneutics

Gadamer’s philosophical hermeneutics have been read and reread, and interpreted and appropriated in a number of disciplines, and for a numbers of theoretical or empirical purposes. For the sake of the argument, the concept hermeneutics is most often followed by signifiers as feminist, social, pragmatic, philosophical, phenomenological, critical, genealogical, clinical hermeneutics or the like. This section does not add to the catalogue, but focuses on critical hermeneutics which comprise feminist and social perspectives as well.

As argued by Code and Kögler above, Gadamer does not take power into account in his considerations. Pappas & Cowling (2003) offer an extension of Gadamerian hermeneutics to incorporate gendered, political and social aspects of understanding. They argue that a critical hermeneutics provides a much needed corrective to Gadamerian hermeneutics by locating conversations in the material, embodied agents who participate in the dialogue (Pappas & Cowling 2003:206). Pappas & Cowling are particularly concerned about the persons who have limited or no access to power structures that is critical to the authentic conversation Gadamerian hermeneutics aims to establish. In the same line of thought, they contend that Gadamer overlooks the extent to which meaning is concretised and hence power-laden, and that the body itself is the crucial site of mediation. These bodies are always gendered (Pappas & Cowling 2003:213-14). Still, they acknowledge his extensive discussion of phronesis, particularly the reflective awareness that is crucial to any true dialogue, and credits his hope that a dialogical interaction will contribute to a sense of well-being for the participants. Most important, however, Gadamer point to lived experience as a vital source of disruption and reorientation of prejudices and cognitive activity (ibid.:222). Pappas & Cowling state their version of critical hermeneutics as supplying the missing components in Gadamer’s account by including materiality and gender (ibid.:225). The point of departure of the present study is to inquire into what people do related to physiotherapy, with a particular focus on the significances of gender. A well suited interpretive paradigm necessarily has to pay heed to these arguments; that the stories told from the realm of physiotherapy are mediated through gendered bodies.

Hans-Herbert Kögler has elaborated extensively on critical and social hermeneutics, and proposes a restructuring of hermeneutic theory that radicalizes and strengthens its position by incorporating the valuable poststructuralist insight into a tenable interpretive theory (Kögler 1996;Kögler 1999;Kögler 2005a;Kögler 2005b;Kögler 2006;Kögler & Stueber 2000). The opening paragraphs in Kögler's doctoral thesis *The power of Dialogue. Critical hermeneutics after Gadamer and Foucault* explains that the title possesses a double meaning that embraces the entire project of critical hermeneutics. On the one hand, Kögler argues, there is the liberating, problem focusing, innovative and unpredictable potential of conversation, which is capable of leading us to new insights and critical self-reflection through the experience of the other. On the other hand, what he means is *power* in the genuine sense of the word, which acts as a constraint upon an open discussion, and is capable of undermining the critical dimension of dialogue. Kögler's project is an attempt to fuse analytical tools offered by discourse analysis and a microanalysis of social-power practices with the insights that hermeneutics has gleaned with respect to the nature of pre-understanding and the dialogical character of interpretation (Kögler 1999:1-2). Kögler's line of thought is cognate to Pappas & Cowling. However, the embodied materiality of the dialogical situation is not discussed explicitly discussed by Kögler. Interestingly though, he uses 'she/her' as a generic personal pronoun in all his writings, which is uncommon, and hence indirectly underscores his critical perspectives. Kögler's re-coining of intentional agency as critical hermeneutics is of particular relevance to the present study. His multiple writings on this topic will be appropriated throughout the thesis.

Svenaesus arrives at hermeneutics' critical dimension through his inquiries into the dialogical hermeneutics off clinical practice (Svenaesus 2000b;Svenaesus 2000c;Svenaesus 2000e;Svenaesus 2003). The medical meeting comes about due to the patient's experiences of illness; a kind of unsettling or uncanny sensation of bodily homelessness in Svenaesus phrasing. Heed must be paid to the most basic difference between the doctor's (or physiotherapist's) and the patient's horizons (or different ways of being-in-the-world) he cautions us – the phenomenon of illness resides in the patient only. Another important difference between the two perspectives is the doctor's expertise and mission to help, and the patient's hope of regaining health and bodily homeliness. Svenaesus adds that differences as social class, culture, gender and the like hold the potential to obstruct the dialogue, and render the interaction a mere clinical investigation (Svenaesus 2000:183-4). Svenaesus' emphasis on

the patient's body, and on the significances of social and cultural differences, arrives at embodiment and material mediated understanding, as well as a power-sensitive analysis – without legitimating these arguments in poststructuralist traditions. Svenaeus argues that we 'are striving to articulate that human life is embedded in a meaning-structure, a horizon of meaning that surrounds every act, action, articulation, or reading' (2004:183). And as Gadamer puts it; where we understand we understand differently. Svenaeus' construal of critical hermeneutics is related to Code's discussions of medical practice in the section above, and exemplifies some preconditions for a recuperative therapeutic encounter.

When inquiring into patients' experiences and aiming at reconstructing their agency, critical hermeneutics opens new possibilities by suggesting that embodiment, materiality, and gender may be construed as resources in a clinical encounter – even though they hold the potential to obstruct and disrupt interaction. By constantly challenging prejudices and historicity, change will emerge, and new purposes may become possible.

Gadamer on Gadamer

Gadamer led an extraordinary and long life, giving lectures and publishing books beyond the age of hundred. These later works comprise comments of the last century (Gadamer & Dottori 2003), dialogical reflections on his reception and critics (Gadamer & Dottori 2003), or collections of later writings (Gadamer 2007;Gadamer & Dottori 2003;Gadamer & Grondin 2006). Living a long life, sustaining an intellectual curiosity and ability until death bed, gave Gadamer a seldom opportunity to comment and rebut his critics, and further the development of his philosophical hermeneutics. *Truth and Method* was written in the 1940ies and 50ies, and was re-edited four times. Of particular interest is his essay on *Language and Understanding* (1970) in which he redefines these concepts (Gadamer 2006c). This essay was delivered as a radio broadcasted lecture in 1970, and published years later in German. The English translation is published for the first time in 2006 (Gadamer 2006b;Gadamer 2007).

Gadamer's general thesis in his radio lecture is

“[...] that reaching an understanding is a process that must succeed or fail in the medium of language. [...] I wish to suggest that the general process of reaching an understanding between persons and the process of understanding per se are both language-events that resemble the inner conversations of the soul with itself, a conversation Plato asserted was the very essence of thinking”(Gadamer 2006c:13).

These short sentences pin point why ‘language’ and ‘understanding’ have brought about critics of linguisticism; a confusion of Gadamer’s ‘language’ with spoken language and semantics. Gadamer rebuts this by elaborating on the cases of silent consent, gestures and exchanging glances. His concept of language is encompassing something else and something more than semantics. Language is also gestures and small behaviours; language does not necessarily involve words. In his conversation with Grondin in 1996, they explain language as the capacity to mean something by something and to communicate it, i.e. to understand something as a sign of something else (Gadamer & Grondin 2006:93-6). Language is the capacity to communicate by any means, which certainly embeds embodied communication and understanding. In his radio lecture, almost thirty years earlier, he explicates that to ‘understand the structures and ordering of our world, to understand ourselves with each other in this world, just as much presupposes critique and struggle with what has grown rigid or outdated as it does the recognition or defence of existing order of things.’ (Gadamer 2006:17).

Tanya DiTommaso’s article *Play, agreement and consensus* (DiTommaso 1996) eloquently illustrates how Gadamer’s hermeneutical “truth”, “understanding” and “agreement” have been misinterpreted by many of his critics. She contends that a Gadamerian truth can only be distinguished from other fabrications in the way in which it comes about or is made in and through play (ibid:407). This truth acknowledges and encourages the play of disagreement and disruptive experiences. When the dialectic interplay among players is evoked, a genuine understanding or truth emerges, through playing with meaningful possibilities. We ought to be ready for an unpredictable and thrilling ‘ride’ which will threaten to shake our previous convictions (DiTommaso 1996:414). Understanding is only possible when one brings one’s own presuppositions into play! (Gadamer 2006b:45)

Following Gadamer, we may reformulate the hermeneutic premises of understanding through language as an acknowledgement of embodied experience, bodily interaction and a bodily communication, as well as an acknowledgment of the critical capacity to question the situatedness of the conversants. ‘Agreement in understanding is more primordial than misunderstanding, so over and over again we will seek understanding’, Gadamer argues. Furthermore: ‘We will not always succeed, but social life together is based on the presupposition that through talking things out with each other, we will overcome being

blocked off from insight, and remain stuck within the compass of our own opinions' (Gadamer 2006c:16-17). Accordingly – our urge to understanding presupposes openness towards the other, and makes new purposes possible. Communication transforms all parties.

To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were.' (TM 2006:371).

Accordingly, engaging in critical dialogue with Gadamer engenders a genuine hermeneutic event of understanding, as play. Gadamer's argument on language and understanding will be further developed in the empirical chapters of the thesis.

The section on critical hermeneutics advanced an argument where embodiment, materiality, social institutions and social differences are acknowledged as resources in social interaction and dialogical encounters; resources which holds the potential to facilitate or inhibit understanding and change. Everything that can be understood, in so far it can be understood, is language, Gadamer argues. In this respect, language is verbal, but also non-verbal; materially and bodily mediated. Understanding and interpretation is understood as an event of play, where prejudices and preconceptions are challenged, and new purposes may become possible due to change. Critical hermeneutics is particularly relevant when the aim of the study is to reconstruct human agency with respect to what people do to negotiate enabling and constraining aspects of therapeutic encounters.

The sociology of everyday life

This section elaborates on the interpretive background of social actors; that which is called preunderstanding, prejudices and historicity in Gadamer's vocabulary.

The hermeneutic premise is that understanding is grounded in the interpreter's background and identity (Kögler 2005b). Kögler, drawing on Heidegger's pre-structures of understanding, elaborates his analysis of Gadamer's concept of preunderstanding, by suggesting to differentiate preunderstanding into a *symbolic* sphere of basic beliefs and assumptions (the symbolic order), a *practical* sphere of acquired habits and practices (unquestionable power relations), and a *subjective* sphere that reflects biographical events and experiences (idiosyncratic individual perspectives). Such a three-dimensional conception of the background proved necessary, Kögler contends, to make problematic how social power

structurally influences belief formation and how such influence can be called into question through critical interpretation (Kögler 1999). Kögler stresses the situatedness of the interpreters, as do Gadamer with reference to historicity. Henceforth, the ideas of context-sensitive critique, where the situated subjects themselves become reflexive about their social situation, are forwarded. This situated, not power-blind form of reflexivity is the ground on which critical hermeneutics bases its methodological and ethical hope, Kögler argues. Kögler's construal of the hermeneutic background has a ring to this study's merging of critical hermeneutics and the sociology of everyday life, and justifies an analytical perspective on gender as a social institution.

Interpretive schemes – social order and social institutions

The symbolic sphere of basic beliefs and assumptions and the practical sphere of acquired habits and practices are constituted through the societal ordering and its institutions, and fed into the individuals lived experiences as enabling and constraining resources. The symbolic and practical spheres of gender are of particular interest to this study. Gender is a social phenomenon encompassing amongst other things practice, conflict, symbols, identity, power, structure and change, and has a significant impact on social order and social interaction. As an analytical move, Martin argues, framing gender as a social institution increases our awareness of gender's profound sociality, and makes gender's invisible or subtle intersections with other institutions more apparent and subject to critical analysis and change (Martin 2004:1250). Social institutions are part and parcel of social ordering, and they persist over time in any culture. Due to endurance, institutions are often described as the controlling, obligating or inhibiting aspects of a society. However, Martin and Berger & Luckmann call attention to their facilitating and empowering effects as well (Berger & Luckmann 1967; Martin 2004). The present study endorses the latter perspective.

Gender scholars have advanced the notion that social institutions are embodied. The material body is the key, they argue, because it is the practices and interactions of real people with bodies that constitute social institutions, e.g. gender (Martin 2004: 1251). In addition to the issues mentioned above, social institutions are characteristic of groups, and entail distinct social practices that are repeated and recycled over time by embodied agents, who internalises their experiences with and in institutions. Henceforth the institutional phenomena

acquire personal meaning to the agents, as do gender. Institutions have social positions, are organised and permeated with power, and have a legitimating ideology. Most important however, how enduring these institutions may be, they are rife with conflicts, inconsistency and contradictions – and they continuously change due to collective agency that can be mobilised over and over again (ibid.:1265).

Accordingly, the case of gender makes up a phenomenon that is relatively rigid, but still fluid, societal and collective. Societal members “use gender” to construct social relations and dynamics of other institutions. Martin argues that this borrowing of gendered expectations to create and legitimate social relations is a clear indicator of its institutional power (Martin 2004:1266).

Social institutions entail power by way of allocating resources, privileges and opportunities differentially. The hermeneutic background which is permeated of power-relations must be made visible before it can be dismantled or analysed. An institutional approach affirms gender’s sociality, and directs attention to the diverse practices of gender; of doing, performing, displaying, asserting and mobilising gender resources. A last argument, forwarded by Martin, is that construing gender as a social institution explicitly acknowledges disjuncture, conflicts and change, and challenges the micro-macro separation. Framing gender as a social institutions is beneficial in drawing attention to its multiple features – ideology, practices, constraints, facilitators and power – and affirming its complexities and multifacetedness (Martin 2004:1264). In other words, social and cultural gender expectations are both enabling resources and constraints upon agency, i.e. the condition of being in action, and the means or mode of acting building on understanding of the situation at hand.

The realm of everyday life

This subsection turns to the embodied practise of everyday living – where the social institutions represent the premises and boundaries for social interaction. Everyday life is action and doings, where creation of meaning is an integral part. The empirical material for this study was created in group discussions evolving from the topic experiences with physiotherapy, with and in the social intuitions of gender and health, amongst many. I have not seen the study’s participants interacting with their therapists, but their stories sometimes

had a ring to my own experiences from the field. Attending an appointment at a clinic is not an everyday occupation or a routine accomplishment as personal attendance. However, some of the participants are “frequent patients”, and hence physiotherapy makes a claim to an everyday status in these patients’ lives. The sociology of everyday life offers an analytical tool appropriate to dismantling the interpretive background. The recurrent referral to common sense, everyday experiences, cultural backdrops, or “chemistry” as descriptions or explanations of social interaction, draws attention towards the common, the ordinary and the plain aspects of interaction, in other words, the subjective sphere of the background emerges as embodied experiences with and in social institutions.

Jacobsen and Kristiansen have co-authored and co-edited several volumes and articles on the issue of everyday life. The introductory *Everyday Life. Sociologies on the Unheeded*¹⁸ elaborates the diverse definitions and broad landscapes of everyday life studies (Jakobsen & Kristiansen 2005). Their contention is to regard everyday life as reaching from understanding banal, minute, trivial and idiosyncratic phenomenon or intimate and individual actions, to understanding and responding to social and cultural contexts, wherein people on a daily basis create meaning, interact, sustain a social order and make a coherent existence. Everyday life sociologies intend to experience, observe, understand, describe, and analyse and communicate the people who interact in concrete situations. This can be construed as studying people in natural face-to-face situations or analysing their stories here from, and building the analysis on the actors’ own commonsense meanings. Jacobsen & Kristiansen do not provide a single coherent definition of everyday life, but rather reflect on the social interaction in our common world, in which we lead our lives and try to create meaning, as well as cooperate to sustain a social order (Jakobsen & Kristiansen 2004;Jakobsen & Kristiansen 2005). Everyday life perspectives are valuable in detecting embodied practices and experiences from the realm of physiotherapy, and Erving Goffman’s studies of face-to-face interactions are particularly fruitful to my project.

From Gadamer to Goffman

The route from Gadamer to the Canadian-American sociologist Erving Goffman was taken by a detour. Establishing play as a key concept, adding a power-sensitive perspective to

¹⁸ My translation of book title

arrive at critical hermeneutics, and approaching gender as agency, seemed to be a one-way ticket to the realm of contemporary performance studies (Bial 2004;Butler 2004a;Butler 2004b;Butler 2006;Carlson 2004;Schechner 2002;Sutton-Smith 1997). Just as my curiosity for play rerouted me towards Gadamer where I found an ontological and epistemological anchor, the performative perspectives rerouted me to Goffman – and face-to-face interaction in everyday life. Goffman provides means to observe human agency as living bodies engaged in understanding as an event of play; in negotiating enabling and constraining aspects of everyday living or therapeutic encounters.

Jacobsen and Kristiansen (2004; 2006) remark and applaud the renewed interest they observe in Goffman. By means of the metaphors on theatre, *play* and ritual, Goffman uncovers the world of common sense, or everyday living, they argue. Theatre and play denote the staging of everyday life, the strategic and dramaturgic moments in living. The metaphor of ritual denotes the elements of caring, trust and respect as prerequisites for interaction (Jakobsen & Kristiansen 2006). The pitfalls of these metaphors were noted by Goffman in *Frame Analysis*:

The problem, in fact, is that once a term is introduced (this occurring at the point at which it is first needed), it begins to have too much bearing, not merely applying to what comes later, but reapplying in each chapter what it has already applied to. Thus each succeeding section of the study becomes more entangled, until a step can hardly be made because of what must be carried along with it. The process closely follows the principle of repetition songs. (Goffman 1974/1986:11, Brackets in original)

In other words, metaphors can evolve to self-fulfilling prophecies, or perpetuate circular argumentation. Goffman compared his conceptual frameworks with scaffolds – built to create other things, and to be erected with an eye to taking them down (Goffman 1959:246). However, if Goffman’s metaphor *play* is translated to a Gadamerian understanding, there is no need to dismantle them, or worry about too much bearing. Goffman’s volumes are detailed reports from his studies of the interaction order. His understandings and his methods evolved as events of play.

Feminist resources in Goffman

Candace West contends in *Goffman in feminist perspective* that Goffman is badly neglected in feminist scholarship, and that his contributions to feminist theory are far more generous

than is publicly acknowledged. Such an acknowledgement is necessary to collect the further benefits of his legacy (West 1996). She reminds us that it was Goffman, who gave us the first sociological understanding of demeanour in his 1950s papers collected in *Interaction ritual* (Goffman 1967), and further the interaction order a few decades later. His ground rules for conversation and interactions, how humans beings use signs and symbols as evidence of social worth and mutual evaluation, deserves credit for supplying a conceptual basis for understanding the minute details in interaction between men and women, the dominant and the subordinate – and between the "sexes", West contends. Goffman's *The arrangements between the sexes* (Goffman 1977) lays out the foundations for the analysis in *Gender advertisements* (Goffman 1979). In the latter book he elaborates on how gender literally is displayed in advertisements, utilising cultural signs and symbols to enhance the impact of the commercial communication.

Several of Goffman's students have contributed to the body of knowledge in gender studies. Nancy Henley (1977) utilised Goffman's general principle of interaction; the principle of symmetrical relations between equals and asymmetrical relations between those who are not. Henley's works *Body politics* (Henley 1977) and *Body politics revisited* (Henley 1995) details in text and drawings how non-verbal behaviour are constituted and differently interpreted with regard use of space, touch, gaze/visual behaviour, facial expression, posture, gesture, and body movements on the one hand, and social status on the other hand. Non-verbal behaviours have a dual function; dominance and intimacy, according to Henley (1995:55). Candace West and Don Zimmerman ground their argument on *Doing gender* and accomplishments on Goffman's detailed studies of doings and the interaction order (West & Zimmerman 1987; Zimmerman & West 1977). These articles are classic texts in gender studies, and in studies focusing on doing difference (Rospenda, Richman, & Nawyn 1998; Traunter 2005; West & Fenstermaker 1995; Williams 2000).

The concept of 'doing' is purposeful to my reflections on interaction in physiotherapy, because gender, age, ableness, disorder, class or ethnicity – along with health and well-being – can be conceived as 'doings'. Hence, doing can be transformed as agency and politics – e.g. body politics or identity politics. In other words, therapeutic relations can be studied as interactive agency and accomplishment, encompassing possibilities for changes. The title of my study, *(En)gendering body politics*, underscores the centrality of these perspectives.

Duran, in her discussion of feminist epistemology and social epistemic, focuses on how Goffman's work, which in her context is viewed as sociolinguistics, intersects with and ameliorates a feminist epistemology (Duran 2003). Goffman's work is particularly relevant, she argues, because he alludes to the behaviour of participants rather than the normativised and idealised account of what participants ought to do. This helps fill in the blanks, and helps us understand how human beings come to know (ibid.:47). Goffman's great awareness of contextual factors, his emphasis on the non-verbal, and the connectedness of interpersonal interaction, makes his work particularly welcome. Duran calls attention to Goffman's notion of face-saving, where the participants try to elicit and/or to provide information in a considerate manner, as particular salient in conversation analyses. Goffman's work is a vein which has been unexplored in epistemology, she ends (Duran 2003:48). Duran's argument ties in with Gadamer's 'everything that can be understood is language', by stating behaviour and contextual factors as conversational aspects, i.e. language. Accordingly, Goffman's perspectives contribute to a hermeneutics of understanding, as well as to an analytical approach to the interpretive background.

The analyses of interaction in physiotherapy may serve as an exemplary case for studying the intersections of social ordering, verbal and non-verbal communication. The abundance of small behaviours, signs given and given off, and the continuous adjustment of behaviour in conversation and interaction, feed into the situation as background resources for interpretation and action. Appropriating Goffman enhance a gender sensitive interpretation of the participants' stories from their doings in relation to physiotherapy and other health care agencies.

Face-to-face interaction

In his writings Goffman analyses his subject matter: the structure of social encounters, those entities of social life that come into being whenever persons – of what ever reason – enter one another's immediate physical presence (Goffman 1961; 1963a; 1963b; 1967; 1969; 1972a; 1972b; 1974; 1983). When we incidentally meet, or turn up to attend an arranged encounter or gathering, we commonly seek information about the other(s), or bring into play things already known about the other(s) or his/her like. We enter social situations with an already

established biography of prior dealings with the other participants, or at least with participants of their kind; and enter also with a vast array of cultural assumptions presumed to be shared. Goffman's collected volumes elaborate on these dialectic evaluations and negotiations in detail, and several of them will be revived in the empirical chapters of the thesis.

Goffman makes the case that the necessity for face-to-face interaction is rooted in certain universal preconditions of social life. He contends that this behavioural order is found everywhere – in private as in public places. In the interaction, as he has described it, engrossment and involvement, at least the participants' attention, is critical. Emotion, mood, cognition, bodily orientation, and muscular effort are involved, as is ease and unease, unselfconsciousness and wariness (Goffman 1983:3-4). This line of thought relate to Gadamer's arguments on engrossment and tarrying. Whereas Gadamer details the dialogue and the event of understanding, Goffman details the non-verbal, embodied and material aspects of the dialogical situation. Like Gadamer, Goffman acknowledges the multitude of potential disruptions to social interactions, and point to their productive effect in bringing interaction forward.

The section on the sociology of everyday life has installed Goffman's interaction order as a necessary amendment to Gadamer's critical hermeneutics. Appropriating Goffman's perspectives makes it possible to detect what people actually *do*, and observe how human agency is played out in practice. Communication, understanding and interpretation are always mediated; through bodies, material props and social contexts. This represents background resources which the interactants can mobilise in their negotiations and creation of recuperative physiotherapy.

Play and small behaviours

Hans-Georg Gadamer was re-introduced to me by Steinsholt's *Easy as Play?*¹⁹ and led me on to a deeper understanding of philosophical hermeneutics (Steinsholt 1998;Steinsholt 1999).

Both in contemporary and historical society there have been play. Western, particularly

¹⁹ My translation; *Lett som en lek?* The 1998 edition is extensive on the philosophy of play; the 1999 edition contains 6 of the 12 chapters of the 1998 edition. Gadamer's hermeneutics is core syllabus in the philosophy of science and the humanities, but was not introduced or appropriated as a philosophy of play.

German, philosophers have dwelt on play.²⁰ Contemporary studies of play and culture are both reviving and criticising this body of knowledge. The questions “What is play?” and “What is play for?” is still posed (Brown & Reifel 2001;McMahon et al. 2005;Reifel 2001;Sutton-Smith 1997;Sutton-Smith 2001). According to these scholars play may be considered a biological feature, as well as a cultural artefact, its fun, its physical, its enhances fitness, its part of our courting system and sexual selection of partners, its adaptive –its ambiguous. Sutton-Smith repeatedly argues in all his writings that the only thing play prepares you for, is more play. The idea of playing, in all its different construes, resonated with my personal experience of physiotherapy; as a therapist and tutor, and as an observer of colleagues’ doings and interactions with their patients.

Gadamer’s argument is that ‘being that can be understood is language’ (Gadamer 2006d:470;Reifel 2001). Everything addresses us by means of language, and Gadamer suggests that understanding is an event of play. In other words, an act of understanding elicited by linguistic utterances or other structure-bearing meanings is hermeneutical (Føllesdal, Elster, & Walløe 1990;Lægroid & Skorgen 2001). Gadamer writes:

I wish to free the concept of play of the subjective meaning that it has in Kant and Schiller and that dominates the whole of modern aesthetics and philosophy of man. [...] We can certainly distinguish between play and the behaviour of the player, which, as such, belongs with the other kinds of subjective behaviour. Thus it can be said that for the player play is not serious: that is why he plays. A definition of the concept of play is that what is merely play is not serious, but it has a special relation to what is serious. [...] Play itself contains its own, even sacred, seriousness. Yet, in playing, all those purposive relations that determine active and caring existence have not simply disappeared, but are curiously suspended. The player himself knows that play is only play and that it exists in a world determined by the seriousness of purposes. But he does not know this in such a way that, as a player, he actually *intends* this relation to seriousness. Play fulfils its purpose only if the player loses himself in play. Seriousness is not merely something that calls us away from play; rather, seriousness in playing is necessary to make the play wholly play. Someone who doesn’t take the game seriously is a spoilsport. The mode of being of play does not allow the player to behave toward play as if toward an object. The player knows very well what play is, and that what he is doing is “only a game”; but he does not know what exactly he “knows” in knowing that. Our question concerning the nature of play itself cannot, therefore, find and answer if we look for it in the player’s subjective reflection. Instead, we are inquiring into the mode of being of play as such. (TM 2006:102-3)

If the concept of play is freed from Kantian subjectivity, Gadamer construes play as an

²⁰ See Steinholt 1998

intersubjective event of understanding. You have to give into play, to be played. No one is the master of play, but play itself. Accordingly there are dangers inherent in play as in any other intersubjective phenomenon. Following Steinsholt, Gadamer's contributions to understanding play, are one of the highlights of the history of hermeneutics (Steinsholt 2001). As such, play creates continuity in life by tying small and large events together, i.e. meaning and understanding can be created through play, a necessary prerequisite for physiotherapy.

There suggests a general characteristic of the nature of play that is reflected in paying: all playing is a being played. The attraction of the game, the fascination that it exerts, consists precisely in the fact that the game tends to master the players. Even when it is a case of games in which one seeks to accomplish tasks that one has set for one-self, there is the risk whether or not it will 'work', 'succeed', and 'succeed again', which is the attraction of the game. Whoever 'tries' is the one who is tried. The real subject of the game [...] is the game itself. The game is what holds the player in its spell, draws him into play, and keeps him there. (TM 2006:106)

Steinsholt and Øksnes make comparisons between play on the one hand, and jazz musicians and bricoleurs on the other. Jazz, play and bricolage engross; they absorb your total interest at that instant in time. Players and musicians develop an aesthetic sensitivity, an ability to interpret the coming by interpreting what already has been – by improvising (Steinsholt & Øksnes 2003). Gadamer makes recurrent analogies to music and arts in his writings, to elucidate the hermeneutics of understanding (Gadamer 2006c). But improvising, playing, and letting go of control is both promising and alarming. Regularly accepted social interaction rules are more or less suspended for the moment, as in play, granting the therapist access to the patient's body. Disruptions and misunderstandings may occur (Sudmann 1999).

Gadamer and Goffman's academic trajectories produced complementary accounts about communication in social life; Gadamer emphatic on conversations and language (apparently "talking"), Goffman emphatic on practice (apparently "doing"), both inquiring into being and social life. Gadamer's argument on understanding as an event of play, and especially his 'being played by the game', resembles Goffman's use of the game-metaphor to elucidate social interaction. Both approaches to social life and understanding acknowledge engrossment and involvement of the participants as critical, and rooted in certain preconditions for social life.

Play as creative dialectics

A key concept in Gadamer's hermeneutical philosophy – *spiel* – risks losing its fertile potential in translation. To native Norwegians, the German *spiel* and English *play* – translates to *lek* or *spill* in Norwegian. The Norwegian concepts are used in a relatively narrow sense, compared to the English or German counterpart, which may constrain the reception of Gadamer's concept *spiel*. A pivotal phenomenon is at risk to lose its fertile potential in translation. Careful reading of Gadamer (in English translation) demands that the full scope of the English noun and verb *play* be taken into consideration to embrace the original German significance. Cross-translations between German, English and Norwegian by authoritative sources as Oxford English Dictionary, Deutcher Wortschatz and Ordnett²¹ reveal an aesthetic conception of play. Play is movement, to bring something into another condition – i.e. to make understanding possible. Play is flickering, its clearance, its pretence and make-believe. Play is dalliance and flirting, to play is to be engaged in something or someone. Play implies that something is at stake, and it is mock, puns and ridicule. Finally, play is drama and game. When we are addressed by a piece of art or music, a cultural artefact, a landscape or another human being, we try to understand, and we are called into play. Play is our muse, and our way of being.

Translating *spiel* to English has been a challenge to several of Gadamer's translators. In Gadamer's major work *Truth and Method* the concept play is chosen. Richard E. Palmer, who has translated the essays in *The Gadamer reader*, notes that "In German the same word, *Spiel*, means both play and game. Our translation will sometimes use one term, sometimes the other, depending on the context, and sometimes also "playing the game", in order to suggest the overtones of motion" (Gadamer 2007:434 n29). Billig uses the game-metaphor in a Gadamerian understanding as "conversation as a game" and in a Goffmanian understanding as "life as a game" (Billig 1996:47-56), both having a bearing for the present study. Tanya diTommaso settles on play-game, to capture the dialectical movement involved in understanding (DiTommaso 1996).

A Gadamerian understanding emerges through an event of play, an unintelligible argument if play is reduced to pastime, physical exercise or education. The present study presupposes the

²¹<http://wortschatz.uni-leipzig.de/>
<http://dictionary.oed.com/>
<http://www.ordnett.no/ordbok.html>

original reading of *spiel*. The concepts of aesthetic sensitivity and creative dialectics embed the whole range of *spiel*, and will be used when appropriate to denote attuned awareness and movement in interaction.

Small behaviours as language

The subject matter in Goffman's studies is the interaction order. He identifies the subject matter as the class of events which occurs during co-presence and by virtue of co-presence of others, i.e. face-to-face interaction in natural settings. The behavioural materials are the glances, gestures, positions, postures and verbal statements that people continuously feed into the situation, whether intended or not. All these small behaviours are interpreted as external signs of orientation and involvement (Goffman 1959:1). Goffman reworks his ideas in every book he writes. However, the details of face-to-face behaviour relevant to the present study are particularly salient in *Presentation of self* (1959), *Interaction ritual* (1967), *Stigma* (1963), *Behaviour in public places* (1963) and *Gender advertisements* (1979).

Goffman uses the concept of giving signs and giving off signs, to denote the continuum from deliberately planned and choreographed signing, to giving off signs that are impossible to rein or hide. Our sign activity is language, in a Gadamerian sense. By signing we communicate ourselves to the situation at large. We are able to arrange our face, hairdo, clothing, bodily appearance, posture, speech and demeanour to a certain extent, and to apply this knowledge more or less strategically. Most of us apply a varied style of clothing, hairdo, bodily movement, language use or manners according to the social context. Professional actors make a living of this, developing commonly shared skills further. Some signs are harder to choreograph; age, skin colour, gender and disability, or social inequality – c.f. poor dental health. A wheel chair gives off signs long before the person seated gets the opportunity to present herself, the same goes for a white cane, skin colour, obesity or conspicuous walking. Following Goffman, social interaction is possible because we mobilise previous knowledge to interpret signs, and assessments are quickly done, and the interaction comes off. The flipside is that previous knowledge encompasses stereotypical constructions of the issue at stake. The signs are not always interpreted as the one giving them off intended.

Appropriating Gadamer and Goffman as theoretical underpinning of this study, construes small behaviours as language. Recall Gadamer: Everything that can be understood, in so far it

can be understood, is language, and that understanding emerges through an event of play. The stories told in the research groups are linguistically mediated experiences and reflections from the realm of physiotherapy. The following chapters demonstrate how my understanding of the participants' stories and discussions emerged, as an event of play.

A hermeneutic competence?

Following Kögler, interpretations in the human and social sciences are oriented at reconstructing intentional human agency, which express itself in linguistic or other purposive behaviour (Kögler 2005b) in the real world. Gadamer's enduring preoccupation was the question of re-grounding philosophy in the real world (Ross 2006). His hermeneutics is oriented to concrete events of recognition wherein we feel ourselves addressed by something. Ross makes the case that this concrete event of understanding is an experience of tarrying. Being in the mode of tarrying is like an extensive back-and-forth conversation, Gadamer explains, that is not cut off but lasts until it is ended. One is completely absorbed in conversation (Gadamer 2006a:71). Ross refers to Gadamer's conversations with Carsten Dutt (in Palmer & Gadamer 2001) and their discussion of the possible cultural loss of hermeneutic acuity; frenetic pace in communication where "tarrying has no place", "an aesthetic culture that withers away" and "tarrying is now disappearing" (Ross 2006:105). The experiences of tarrying as engrossment and being played, and Gadamer's recommendations of talking things through, might be critiqued for being elitist construes of being. Gadamer was through and though Socratic, and held the Socratic dialogue as an ideal. Contemporary society, as the ancient, does not grant all citizens the privilege of engaging in time-consuming dialogues – to uncover prejudices and reach an understanding. Pappas & Cowling (2003) warn that such an ideal construe of the dialogue may mute many.

The subject matter of this study is how patients relate to and enact physiotherapy. As has been suggested above this particular meeting holds the potentials to make nascent conversations become Socratic dialogues. Physiotherapy literally takes time to accomplish, as such tarrying may already be present as an opportunity for engrossment. The Socratic dialogue may evolve through a broader register of language use – mediated through spoken and bodily interaction. However, social inequalities in health and health care still persist. Those who do not hold the means to attend physiotherapy are bereaved from this opportunity to "talk things through" with a physiotherapist in a Socratic fashion, or engage themselves in

negotiating health and well-being. However, Gadamer reminds us that healing through dialogue is an eminently hermeneutical phenomenon (Gadamer 2006b:50). Gadamer presses that hermeneutics is more than just a method of the sciences. Above all, he remarks, it refers to a natural human capacity for understanding (Gadamer 2007:248). If hermeneutics denotes being and a natural capacity, healing dialogues are available outside the realm of physiotherapy as well.

A last caution on hermeneutics (or other applied theories) is appropriate. According to Kögler theory should not define what good life is, nor be allowed to prescribe what subjects should think or do. Self-empowerment, while dependent on social and cultural resources, and limited by interpretive schemes, should be left to the subjects themselves, he argues. Critical hermeneutics should do no more than provide a tool for situated selves to use in recognising and perhaps realising hitherto invisible life-possibilities (Kögler 1996:38). The hermeneutic competence to be encouraged should be applied to make new purposes possible. The participants in this study will make this case.

Closing remarks

This chapter presented the theoretical underpinning of the study. Critical hermeneutics and the sociology of everyday life are tied together by coining play as pivotal for understanding and interaction, and by embedding small behaviours as part of language. According to a hermeneutic premise understanding evolves as an event of play grounded in the interpreters' background. Social institutions as gender are part of this background, and inhibit or facilitate understanding, agency and social practice. Interpretations in the social sciences seek to reconstruct agency, to detect what people actually do rather than ought to do; e.g. what patients do to negotiate enabling and constraining aspects of therapeutic encounters.

The next chapter turns to the methodical aspects of the study, and introduces the participants.

4. Enacting group based research

This chapter reviews and discuss focus groups as a research method, and gives reason for the choice of this method for the present study. Feminist resources are indentified in focus group methods, and the social context of focus groups is discussed. The composition of the groups and details on running the groups are presented and discussed in consecutive sections, and methodological considerations are summarised towards the end of the chapter. The last section presents the participants in the study.

Focus groups

This section discuss how and why focus group methodology are justified to inquire into what people do to negotiate enabling and constraining aspects of therapeutic encounters.

Appropriating Goffman's perspectives, reveal research groups as gatherings, as social situations where people meet face-to-face and mutually and immediate interaction occur. The situation at large gives behavioural clues. A research group is an occasion which is structured in time and place, where the persons gathered come close together and openly cooperate to sustain a single focus or attention (Goffman 1963a;Goffman 1967;Goffman 1981). The importance of interaction in research groups are underscored by several proponents of focus groups (Agar & MacDonald 1995;Bloor 2001;Fern 2001;Hollander 2004;Jowett & O'Toole 2006;Kitzinger 1994;Kitzinger & Barbour 1999;Kroll, Barbour, & Harris 2007;Marková et al. 2007;Morgan 1996;Myers 1998;Owen 2001;Smithson 2000;Warr 2005;Wilkinson 1998a). However, interaction in focus groups are facilitated or constrained by the researchers' aim of the study, research questions or epistemological stand, and the social context of the focus group.

Group based research methods are available in different versions. Following Morgan (1996), any data collection technique that relies on group interaction on a topic determined by the researcher can be deemed focus group research if three essential components are present (Morgan 1996:130). Focus groups first and foremost are a research method devoted to data collection. Second, it locates the interaction in a group discussion as the source of data. Third, it acknowledges the researcher's active role in creating the group discussion for data collection purposes. Morgan, as a researcher with a huge impact on focus group research,

proposes a generous and inclusive approach towards the (possible) difference between focus groups and other research groups. Morgan treats focus groups as tendencies, with many useful variations that can be matched to a variety of research purposes. Smithson prefers the term controlled group discussion, occurring in a specific controlled setting (Smithson 2000), whereas Wilkinson states that focus groups at its simplest is an informal discussion among selected individuals about a specific topic (Wilkinson 1999a).

When first introduced to the focus group method it seemed to me as a variant of problem-based learning (PBL) tutorial groups. Until recently, no one had made this intersection problematic. Wibeck et al (2007) suggest that if the analytical focus shift from content analysis to an analysis of what the participants themselves are trying to learn, it is possible to explore how they are trying to understand and conceptualise the issue in question (Wibeck, Dahlgren, & Öberg 2007:263). They recommend researchers to take a closer look at PBL-related studies. Analyses of focus groups relentlessly pose the question “What are they talking about?” to the material. Wibeck et al suggest that this question is exchanged with the following: “What are they trying to learn?” As trained within this pedagogical tradition, I regret that I complied with advices of not exploring these intersections. As Owen (2001) points at, focus groups are advocated increasingly as a useful method to obtain the views of clients, care-givers, or health service providers (Owen 2001:652). The questions of learning are particularly appropriate in these settings. Kroll et al (2007) contend that many focus groups participants find their participation enjoyable, empowering and informative. They experience participation as an opportunity to learn from one another, as well as to contribute to social and policy change (Kroll, Barbour, & Harris 2007:691). When people are construed as intentional beings, a learning perspective on agency is fruitful.

Marková et al (2007) introduces focus groups as an analytical means for exploring socially shared knowledge, e.g. social representations, beliefs, lay expectations of diverse social phenomena (Marková, Linell, Grossen, & Salazar Orvig 2007), e.g. what people do and think related to health concerns. Their point of departure is that humans live in a world of others’ words, a perspective developed from the ideas of Mikhail Bakhtin. Every individual makes his or her world in terms of others by dialogically constructing and re-constructing the social world as multifaceted and multivoiced realities situated in culture (2007:8). Marková et al

contend that their dialogical considerations about focus groups have specific consequences for the analytical tools that could be used to analyse focus groups discussions, and to account for the construction of socially shared knowledge. Four main assumptions are pinpointed; i) considering focus groups as group discussions, ii) considering the subjects' heterogeneity, iii) considering a focus group discussion as circulation of ideas, iv) considering focus groups discussion as a situated activity which relies on historically and culturally shared social knowledge (2007:48-50). The focus groups in the present study are considered in this manner, drawing on Goffman and Gadamer (who both read Bakhtin).

Following Wilkinson (1998b), focus group research is not tied to a particular epistemology, and may be used either within an essentialist or constructionist paradigm. Although focus groups researchers seldom offer epistemological statements, Wilkinson's review note that essentialist epistemologies predominate, although there is a great slippage between essentialist and social constructionist epistemologies. An essentialist approach tends to view focus groups as an instrument for quick data collection. Several participants are gathered, bringing prefabricated opinions to the group, which subsequently are accessed or elicited of the researcher. Focus groups research conducted within a social constructionist epistemological framework does not utilize the notion of pre-existing ideas or understandings. Rather, sense-making is a product of collective effort, in the course of social interaction between people (Wilkinson 1998a:186, 197 n4). A constructionist approach appreciates that knowledge always bears the mark of its producer. Within a 'constructionist' framework, the researcher gets to observe these processes, and may make the interaction as such the primary focus of the study. In the sense that focus groups are conducted with several participants, they are essentially social moments (Jowett & O'Toole 2006:458). Applying Goffman's perspectives on the social organisation of gatherings make for an extremely rich material of focused and unfocused attention, of improprieties, verbal or embodied non-verbal signs (Goffman 1959;Goffman 1963a). The present study's epistemological grounding in critical hermeneutics embeds it within a social constructivist framework, according to Wilkinson's classifications.

Smithson argues that the range of argumentative behaviours exhibited by group participants result in a depth of dialogue not often found in individual interviews (Smithson 2000). She rejects the use of focus groups as a quick data-gathering method, ending up with some "sound

bites” with which to illustrate themes. Quick data-gathering ignores the complexities of focus group behaviour, she argues. Smithson suggests viewing focus groups as a performance by all concerned, with participants and researcher all positioning themselves through the group discussion (Smithson 2000:116). This is in line with Goffman’s gatherings as mutually created social situations. Opinions stated in the group should be viewed not as previously formed and brought into the group setting, but as constructed in this particular social situation, with reference to the larger social context of the participants and the study. The understandings created during the session do not belong to any individual or the whole group; they are discourses emerging from this context, telling of the social order it is embedded in. Warr (2005) contends that focus groups explicitly bridges personal and social contexts, because the sociable interactions that take place are a blend of private and public accounts (Warr 2005:222).

Överlien et al.’s arguments share some of Smithson’s concerns (Överlien, Aronsson, & Hydén 2005;Smithson 2000). Contrary to the belief that the focus group method is designed for low-involvement topics and mainstream groups, their analysis suggests that the method can indeed be used for high-involvement topics. They also argue that other methods are not likely to give deeper insights and that the focus group method can be seen as a less intrusive method. Deciding on high/low involvement on behalf of other people is a delicate matter. My study draws on several sources; insights, experiences and knowledge gained when working on the ‘Gender sensitive rehabilitation’ project (Taksdal 2003); those of physiotherapy colleagues, friends and acquaintances; and my own reminiscences of professional experiences in the field of health care and physiotherapy. This select body of knowledge lends support to interpreting experiences with physiotherapy as high-involvement topics.

To summarise this section, focus group are social gatherings or mutually created social situations where immediate evaluation and interaction occur, the researcher is participating in the discussion (by way of inhibition or facilitation), and focus groups may be viewed as tutorial learning groups. Focus groups are situated discussions or circulation of ideas, and a performance of all concerned, and they may provide in depth knowledge about high-involvement topics. As such, focus groups are well suited to meet the aims of this study; to inquire into patients’ experiences to gain knowledge about possibilities and constraints for

recuperative encounters with physiotherapist and to learn how they conceive and enact health and illness, with particular reference to gender.

Feminist resources in focus group methodology

Many feminist researchers find focus groups particularly useful in offering a contextual method which give voice to marginalized groups, providing a non-hierarchical structure and enabling collective reflections and non-oppressive research method (Braun 2000;Frith & Kitzinger 1998;Jowett & O'Toole 2006;Kitzinger 1995;Lupton & Tulloch 1996;Wilkinson 1998b;Wilkinson 1998c;Wilkinson 1999a;Wilkinson 1999b). Wilkinson contends in all her papers that the problems of artificiality, decontextualisation and exploitation have led feminist researchers frequently to advocate qualitative approaches. Wilkinson argues that these three problems can be addressed through focus groups research. The method is closer to everyday interaction than any other methods, particularly when pre-existing groups are employed. This mirroring of everyday socialising avoids artificiality, in her opinion. The problem of decontextualisation is solved by acknowledging the social context of the group itself, which gives researchers access to observe how the co-construction of meaning through interaction (Wilkinson 1999a:224-9). The third problem, exploitation, is avoided by redistribution of power. The researcher's influence is inevitably reduced, simply by virtue of the number of participants. This is regarded as a resource, not a problem. Participants challenge each other, as well as the researcher. Interruptions, laughter, jokes, badinage and cryptic comments of the participants may cut across and over the moderator's research agenda. In a feminist perspective, this is an advantage that enables participants to contribute to setting the research agenda (Wilkinson 1999a:231). This particular style of communicating — interruptions, laughter, jokes, badinage and cryptic comments — flourished in the groups and made contributions to my research agenda. The case of laughter will be discussed in chapter eleven.

Wilkinson and Kitzinger are widely cited senior feminist researchers, promoting focus groups as a feminist method. However, their arguments were directed at debates of the 80ies and 90ies. At the time, focus groups were more known as a tool for marketing research, and conducted as 'individual interviews' within groups – i.e. asking questions and taking rounds for collecting individual answers, posing next question and so on. Their justification of the

methods strengths should be interpreted in light of history. Nonetheless, Wilkinson's and Kitzinger's work has contributed to the increasing application of focus groups in health and social care research. The disability movements, citizenship movements and women's liberation movements criticized traditional methods that never included people marked as different (women, blacks, disabled, deaf, sick and so on). Focus groups are one answer to their claims. The concept of feminism is denoting a critical perspective, but more important, it denotes a normative siding with marginal or disadvantaged groups.

Focus groups provide a forum for the exchange of views and opinions in a collegial, supportive atmosphere, especially for people from otherwise marginalised groups (Kroll, Barbour, & Harris 2007). In the area of disability studies research, focus groups have gained popularity for their open format and flexibility of implementation. In accordance with feminist researchers, Kroll et al (2007) point to the fact that older people, people with disability and women have hitherto been systematically excluded from many large quantitative studies. They call attention to the usefulness of focus groups with these populations, where the participants are engaged as active contributors to the research project, rather than delivering data to a impersonated project (Kroll, Barbour, & Harris 2007:690). Focus groups hold the potential to redress this, they contend, an argument supported by Owen (2001). The participants in her study, severely mentally ill women, are seldom recruited to active participation in any study. In the present study, I have paid attention to such advices, and engaged some of the participants as active contributors to the project – as reviewers, co-workers and participants – as will be outlined in the section 'Composing the groups'.

Feminist resources are identified by construing focus groups as social gatherings closer to everyday life situations and everyday life communication forms, where the situatedness of the groups are acknowledged, and power is redistributed between researchers and participants. Feminist researchers are emphatic to impart how focus groups research is particularly relevant when relating to marginalised or disadvantaged groups of people. Many of the participants in this study are marginalised, discriminated against or disadvantaged due to their health/illness status. However, they are also relatively speaking privileged due to their access to diverse health care agencies, and for holding the means to participate in a research group, compared to the participants in the studies referred above. The participants in the

present study are not comparable to impoverished unoccupied people, or people of colour discriminated against in the USA. Nevertheless, the methods strengths are of no less importance to the present study.

The social context of focus groups

This section turns to the situatedness of social gatherings, including focus groups. A select review of articles on the issue are presented and discussed in relation to the present study.

As discussed above, focus groups are social occasions, and the context of the session feed into the discussion. This is a basic premise in Goffman and Gadamer's perspectives, but not always acknowledged in group based research. Jowett & O'Toole (2006) reflect that any research that analyses people's accounts of their lives must include awareness of the social context in which such accounts are expressed and of the social and cultural locations from which they are drawn. Their reflections have shown that the social and cultural locations from which participants' accounts are drawn can impact significantly on responses to the context in which those accounts are expressed (Jowett & O'Toole 2006:468-9). Some of their participants did not feel comfortable with the group setting, which made them change research design in one of the studies discussed in the paper. Ethnographic field studies eventually gave Jowett & O'Toole access to the features of interest (ibid.). Hollander contends that participants in a focus group are not independent of each other, and the data collected from one participant cannot be considered separate from the social context in which it was collected (Hollander 2004:602). Within a learner-perspective, participants, rather than acting as individual group members, try to establish a common ground, and to figure out how to add their contribution to and expand the common ground (Wibeck, Dahlgren, & Öberg 2007:261).

Smithson (2000) argues that focus groups should be viewed as a performance by all concerned, participants and researchers positioning themselves through the discussions, i.e. researchers are partaking in this performance as group participants, they are not observers or traditional interviewers (Smithson 2000:105). Smithson contends that participants themselves use the focus group in ways not always anticipated by the researcher (ibid.:116). If, as suggested, the groups are conceived of as gatherings, the researcher should hold her expectations in abeyance, and negotiate the use of the group as a participant.

Hollander (2004) advances the understanding of focus groups in two ways. First, she takes a sociological approach to the method, applying our knowledge of the effects of social context to the focus group. Second, she identifies several different types of social contexts that impinge on focus groups and their participants (Hollander 2004:606). Focus groups, like all research contexts, are social contexts. Participants interact with each other, with the researcher and assistant, and with others who are not present but whose imagined presence affects the participants. It's a multidimensional context, of which Hollander lists four aspects that impinge on the discussion. First, the associational context, represented by the common characteristic that brings participants together; e.g. experiences with physiotherapy, or being befriended, team mates, neighbours, or affiliated with the same organisation. This may affect the course of the discussions because of its long-term ramifications for the participants. Second, Hollander list status context, as gender, education, age, social class or authority. Gender is a particular salient status, activated in any social situation. Which status impinges the most is an empirical question. Third, there is the conversational context. Focus groups are unusual social experiences for most participants, and they may interpret them in different ways; e.g. a group counselling or a meeting. Finally, she draws attention to the relational context of the group; the degree of prior acquaintance among the participants, and the silent participants. (Hollander 2004: 613-22).

Hollander (2004:627) suggests we must think carefully about how participants' responses are being shaped by the context, composition and facilitation of the group. However, it's naïve to suggest that even superlative facilitation will remove social desirability and self-presentation pressures. This is a lesson already taught by Goffman. Peoples' daily lives often include secrets, exaggerations, and half-truths, and these are also likely to be replicated in focus groups that mimic people everyday contacts (Hollander 2004:628).

Agar & MacDonald compare and contrast their experiences with focus groups and ethnography (Agar & MacDonald 1995). Their blunt conclusion was that the single focus group they conducted was both a complete failure and a success. Their group produced something of value, though the value derived from its relationship to other ethnographic work (ibid.:1995:79). Focus groups explore socially shared knowledge, as Hollander (2004)

explicated. Agar & MacDonald coin these articulated and shared knowledge folk models. Their methodological point however, that without knowledge of folk models in beforehand, the conversation in their groups would have been unintelligible. Previous knowledge of the field at large and the folk models in particular, are part of the researchers' interpretive backgrounds. Prior knowledge serves as a base to evaluate group exchanges against. A single focus group can show a researcher some new territory, but it cannot tell you much about what you have seen (Agar & MacDonald 1995:85). In other words, the method would produce nothing of value compared to ethnographic methods.

Following Agar & MacDonald my previous experiences from the field and the folk models of the time, are an invaluable part of my interpretive background. Additionally, in Gadamer's and Goffman's perspectives my interpretive background of previous experiences, or prejudices, are put to play in focus groups, constantly being challenged and juxtaposed by the participants' dialogical interchanges. During previous ethnographic work Agar & MacDonald (2004) got access to folk models or socially shared knowledge on substance abuse, which subsequently made the material created in their focus group intelligible. The study (*Engendering body politics*) draws on previous elicited folk models in the field of question, where 'Gender is (also) a job' (Sudmann 1997) and "Gender sensitive rehabilitation" (Taksdal 2003) are of particular importance. Following Agar & MacDonald's lead, I do believe that what was learned in these projects make up an irreplaceable part of my interpretive background.

To sum up: The social context represents the premises for the interaction; i.e. it may enable or constrain interaction and discussion. The participants in this study are recruited from existing social groups, or are friend of friends. Their life trajectory may have crossed several times before this gathering, or are bound to cross in the future. As such, participation in a research group may ramify in to several parts of their lives – and inhibit or facilitate participation or how participation is enacted. Different groups could produce a different material insofar my material do not represent socially shared knowledge or folk models. Social statuses as age, gender, education or employment are quickly collected and evaluated – and imprint the interaction in ways not directly foreseeable. The groups are constructed to diminish the impact of gender and age by making them single-sexed, and grouping participants close in age-grade. However, this argument can be turned up side down. By making gender and age-

grade an organising category I have honoured this difference and made it visible. The male C-group made this problematic to us. The female researcher became *gender* and *age*, and my assistant became *age*, and neither facilitated the discussion. The researchers are both participants in a social gathering and a social context of the research.

Agar & MacDonald (1995:83) asks: “Who are those silent voices in the group? Why aren’t they talking? What do they have to say?” I could add, “What is muted and what is possible to articulate in the group?” Due to changes in study design, Jowett & O’Toole (2006) were given the possibility to interview some of the group participants later. This made for a rich material, they argue. Acknowledging these questions and experiences, I would expect to learn more or something else if individual interviews had been conducted as a supplement. In light of experiences, however, I’m not convinced that an individual interview would have turned out as fertile if the informants had not participated in a group already. None the less, this was beyond the practical and economical scope of the study.

Agar & MacDonald have brought a second issue to the fore, relevant to my study; every focus group has a story behind it, which belongs to the focus group data. These data comprise methodological, methodical and pragmatic considerations from designing a study to writing up the results. For without it them, it’s difficult to evaluate the scope of what was learned (ibid.:79). The next section turns to these issues.

Composing the groups

The project plan attached to the application for the research fellowship, suggested interviewing men and women individually. Before the scholarship was granted, I revised the methodical platform for the study due to learning in action. While working on the ‘Gender sensitive rehabilitation’ project I was repeatedly struck by the richness and profundity of insights generated by the groups, as were the participants themselves. The interchange of experience and knowledge across the divide between health care providers and receivers, and across professional divides, made for fruitful discussions and unexpected insights. Together, we created insights and knowledge hardly accessible by other methods. Conducting a large scale group based research project is demanding, henceforth I acted as or co-researcher and a ‘methods-apprentice’. Being two researchers airing and discussing the group sessions

beforehand made for a rich material, and an exemplary methodical experience on my behalf. We worked as a team at the sessions, and summed up and discussed the outcome in the weeks that followed. When two researchers are working together, their different qualifications can be utilized better in that one can keep control and see to it that the sessions stay on track while the other can facilitate the conditions for improvisation and letting go. This arrangement makes room for creativity and stringency, where the participants' *different* qualifications more explicitly are engaged and utilised. This is a genuine hermeneutical approach – utilising the productive potential of tensions and disruptions.

The second issue evolved from personal and professional experiences in another field all together (Sudmann 2001b). Whether living with chronic illness, a demanding athletic career or a disabled child, we all strive to make sense of, and create coherence in our lives. Our complex efforts sometimes include seeking guidance or help from professionals. The characteristic and reiterated critic posed towards a range of professional practice from disability rights advocates, women's organisations or advocates of other disadvantaged groups, concerns the professionals' comprehensive claims to their lives. From the receiver of professional services point of view, the effect of the services may be acknowledged as significant, but they were nevertheless minor events in their lives in the long run. 'A surgical intervention is only a surgical intervention, after all.' to cite Gadamer once again (Gadamer 1996). The main challenge when receiving services appears to be to figure out how to reorganise the rounds of daily living to make incorporation of professional services viable. Accordingly, inquiring into experiences with physiotherapy adumbrates a wider range of daily living concerns and embodied enactment.

The third methodical consideration brought to the fore during this period, is that being a woman and interviewing men about bodily proximity and gender in physiotherapy alludes directly or indirectly to sexuality. The cultural backdrop, against which the pleasure of bodily touch as massage is projected, is revived in gendered cross-sex interaction during research interviews. The latter fact presupposes the heterosexual mode of ordering women and men, independent of the interactants personal preferences (Braun 2000). An interview situation may mimic other social relations or hierarchies where women are subordinated to men. This is particularly challenging for women interviewing men. In Willott's (1998) studies of men, unemployment, crime and constructions of masculine identity, she gained an increased

awareness of the conflicts and contradictions around power in her relationship with the men. As a woman, and as a feminist researcher, she became an outsider within, she contends. As others had experienced before her, this double-edged role gave rise to both anger and despair, a feeling of being trapped in a stereotypical heterosexual conversation format (Willott 1998). However, downplaying the impact of gender in the interview situation might obscure reports from the area of study, as well as masking personal constraints or emotion work. There are several ways of attending to these methodical challenges. According to Prieur and Taksdal, both of whom are female researchers, known for their study of men who buy sexual favours, the gender of the researcher is probably of less importance than knowledge about the field of inquiry, and being skilled in posing follow-up questions (Prieur & Taksdal 1989:19-20). Many of their male interviewees appreciated being interviewed by a female researcher; they opened up more easily and were ready to acknowledge and appreciate the sexual undertone of the interview.

Never change a winning team?

As indicated in the sections above, working in research teams are more fun and more productive than working alone. I invited a few carefully selected participants of the 'Gender sensitive rehabilitation' project (Taksdal 2003) to review and discuss the project plan for my study and to consider extending their participation to encompass my study as well. Including people with disability in training of moderator and preparatory efforts are recommended (Kroll, Barbour, & Harris 2007). The persons invited were not invited because they were disabled, but because they were particularly knowledgeable about the issue in question. Four participants, one personal assistant and the researchers were present. The three others invited, didn't make it due to practical constraints.

At this session we discussed the aim of the study (*En*)gender body politics in light of the structural organisation of private and public physiotherapy, the gendered work division, and the statistical categorisation of the service users. On the white board, a 'sampling matrix' was worked out as a collaborate task. The matrix was designed to range from health to ill-health, from the medically explained disorders to the medically unexplained disorders, from acute/temporary to chronic conditions, congenital to acquired bodily afflictions or impediments, all varying through lifespan and in relation to gender. It was designed to

identify major groups of physiotherapy users, and encompass structural work division between public and private physiotherapy services, and gendered work division between female and male physiotherapists. Theoretically, the aggregated body of experience of the potential research group members would run the gamut of Norwegian physiotherapy, and be sensitive to cultural frames or social institutions interfering with therapy. All present at the preparatory session accepted an invitation to participate as co-researchers and/or organisers in my study. Due to practical constraints in the year that followed, only a few had the means to take on this commitment.

My participation in the ‘Gender sensitive rehabilitation’ project was as a co-worker/researcher. The tables were turned in this study. Additionally, a male sociologist and a female disability rights advocate were invited to act as assistants/co-workers (both present at the preparatory session). They had participated in the rehabilitation project in an outstanding way; being attentive, outspoken, reflective, curious, and had expressed a positive opinion of that way of working together. In sum; i) they had experience of group method, gained at the last years’ assemblies, ii), been introduced to and practiced gender sensitive analysis, iii) they were literally closer to the practice of rehabilitation or physiotherapy than the researchers, iv) their biological sex was relevant as a common gender specific experience, and as a means of creating same-sex research groups.

Recruitment

During the discussions in the preparatory group, I was offered help with recruitment and advice. I chose to make contact with “key informants” in natural groups, i.e. activist organisations, sport teams, swimming clubs and likewise, and asked them to organise groups for the study. These organisers then contacted likely participants. There are several good reasons to use this method. Organisers have access to more people; they guarantee the quality of participants and act as a PR agent for the project. Organisers are more likely to get a straight yes or no from people they approach, and people who agree are more likely to turn up. And, ideally, using organisers saves time. When people had agreed to participate, they received information about the study and an informed consent form from the organiser, or by post or e-mail from me (see Appendices, in Norwegian). Due to practical constraints, I partook in recruiting some of the members of the groups of ‘adults with disabilities’.

Recruitment went ahead without involving practising physiotherapists to avoid indirect assessments of potential participants, and, to avoid that the therapists' name became known to me and made me recognise former colleagues, students of physiotherapy or friends. Since I had no contacts in the sports world to act as an organiser I asked a teacher of physiotherapy at the University College to put me in touch with an active male athlete and an active female athlete, preferably at the elite level. These students contacted friends and team-mates, and organized a group session each.

The two groups of people with a disability were mainly put together by two (male and female) employees at a medical equipment company. Several attempts to recruit organisers who knew enough people to fill a group session failed. Many were willing to assist, but didn't have the means due to diverse health related concerns. I had assumed that organisers had to have a disability themselves, and it was only after a friend (with a disability) had pointed me in the right direction that I found the two employees. This was a fruitful connection. They arranged to hold the sessions at their workplace, which solved problems concerned with accessibility and parking. I made direct contact with several potential participants to the female group.

The four groups of people with rheumatics and heart and lung disorders were put together by my female assistant in the group discussions. As an activist, she has a large circle of acquaintances, colleagues and friends, and could manage to organise as many groups as needed with any characteristics wanted. One of the male groups had to be postponed. This I followed up and organised myself.

Each group was "overbooked" to ensure a minimum of four participants in case of dropouts. All organizers were told that the ideal composition of the groups was six members and two researchers. This led organizers to aim at securing at least six "certain" participants. Dropout rates are regularly lower when participants know the organiser and/or each other; the venues are easily accessible and resemble what people are used to in their everyday lives.

Recruitment presupposes preparation, contact and follow-up in repetitious circles. Whether an organiser or the researcher are doing the foot work, this is extremely time consuming, a

fact acknowledged by most researchers (MacDougall & Fudge 2001). Noy suggests to make a particular case of studying snowball sampling (Noy 2007). His suggestion is most interesting, but is beyond the scope of this study.

Incentives

The participants were not given any incentives beforehand, but all received a seasonal chocolate gift after participation, and transport expenses were refunded. Most of the participant said they had agreed to join in because it offered a 'pay-back opportunity', a way of expressing their appreciation of good relations with the organiser, the health and social care service providers, or both. Several participants thought the project looked interesting, and hoped participation would pan out well. The organisers, who did most of the practical and organizational work to assemble the groups, were rewarded with gifts (wine and chocolates, additional fruit baskets at the medical equipment company) after the sessions. They also had their expenses refunded. Neither organisers nor participants were told about the gifts in advance, only refunds were offered. My research assistants were paid hour by hour.

Conducting focus groups

Hermeneutics is forwarded as a qualitative research approach in professional practice (Paterson & Higgs 2005; Smithson 2000), and a means to linking theory and practice in human sciences and health. Slattery et al (2007) and Paterson & Higgs (2005) particularly call attention to the aesthetics of a hermeneutic approach to research and understanding. Dialogue, the productiveness of disruptions and the importance of aesthetic awareness are appreciated by all. Slattery et al (2005) contends that while hermeneutics does involve critical reflection, it is also a kind of knowing; a knowing that becomes an opening to possibilities, agency, and empowerment (Slattery, Krasny, & O'Malley 2007:552). Hermeneutics is dialogue and interaction, and is appropriated through the dialogues and interactions with my assistants, co-researchers and first and foremost the participants. I tried to create a dialogical meeting with the participants, and have tried to keep up a dialogical and dialectical relation to the written material in lieu of their living presence. Posing questions, listening and suggesting interpretations are a perpetual endeavour, which often comes to an end due to practical

constraints. Following Myers (1998), these constraints makes it possible to understand, and which is an important premise in critical hermeneutics.

Working paper and topic guide

A working paper, including amongst other things a topic guide, was made for each group to ensure key features of the group were addressed, i.e. gender, age, disorder, sport, acute/chronic physical problems and so forth. The content of each working paper was outlined on the front page under paragraphs such as “Main Purpose” and “Today’s Leatherman™”. These multipurpose tools pinpointed what to listen and look for, inquire about, which feelings to observe or think about during the session – and served as a conspectus of the working paper. One of the general goals was to make everybody feel comfortable and able to participate in the discussions. As group conductors, we needed to establish a feeling of confidence in the groups, and show by our own behaviour that the material we were about to create were already present in the room – as a collective repository of experiences, meanings, responses, exchanges, ideas and so forth. The working paper also included notes on particular issues for each group, practical introduction (e. g. about signing the informed consent form, time schedule), thematic introduction (i.e. aim of the study), group-specific introductions, and a short list of open ended questions – as a reminder for the group conductors. The working paper was reviewed for each group. Certain topics were added or removed; the roles of my co-researcher were outlined to embrace how I thought she/he could facilitate in the group discussions and give me feedback on my role. Sometimes abstracts or drafts were attached (e.g. play and masculinity, theory of science paper). Before the group met we discussed and edited the working paper, highlighted, erased or added elements. As a consequence, the working papers evolved through evaluating their usage together with my co-researchers before and after group sessions, and through reviews and guidance of a colleague specially trained in problem based approaches. En example is provided in the Appendices (in Norwegian).

Preparation and debriefing

Before each group session I had a conversation with my assistant. Before the first group with each assistant we spoke on the phone a couple of days ahead, and arranged to meet well in advance of the scheduled group session. On later sessions we reduced time in advance,

travelling together to the venues gave ample time for preparation. Particular issues were discussed before hand and after the sessions, including division of roles in the actual setting. Advices were shared. The conversations before and after the group sessions (up to an hour before, up to an hour afterwards) were recorded.

Field notes and research diary

Every session generated new ideas, new and interesting topics to bring to the next group. After the sessions I noted my spontaneous thoughts in a research diary – either in a hardbound note book or on the computer, depending on which was at hand. Later on this was converted to a “post-session-memo” outlined with similar section for all groups; new ideas, participants, place/context for the group-session, preparation, running of the group, follow-up work (detailing when the recorded material was tabbed, where and when I listened to the recording, whether I was walking outdoors or seated indoors, when the transcription started and finished), notes taken along the way. The new ideas, advices or questions were later inserted in the next working paper. New topics ranged from the lack of or overwhelming response to a question posed, or an issue brought up by the participants, e.g. pain experiences, convalescence abroad, or more didactic considerations about facilitating a group discussion; e.g. introduction, conducting the group, the relation between myself and my assistant, or more prosaic issues as what to serve.

Creating an ambience

During the period of creating and producing the empirical material for this thesis I have met a lot of people who have shown me great hospitality. They have offered me help or guidance, contributing in different ways to make up the material. I have tried to act in the same manner towards the participants in this study by showing hospitality. I have greeted the eight groups by offering morning or afternoon refreshments, cold and hot beverages, mineral water, seasonal fruits, biscuits and chocolates. Additionally I brought along kettles, cutlery, table cloths, and a small farewell chocolate gift.²² Halkier recommends researchers to offer some food and drinks, and a small farewell gift; “it’s doesn’t have to be three bottles of red wine” (Halkier 2002:70). All authors cited so far, stress the importance of a non-threatening atmosphere, but none details the importance of well-being as Taksdal (1999).

²² The pre-review group received the same treat, including lunch.

Setting

The place and time of the group sessions were arranged by the organisers, in cooperation with me. Locations were chosen which would be familiar to the participants and easily accessible. Four of the groups met in a rented room at a municipal health service centre; two groups met in a meeting room provided free of charge by a medical equipment retailer; one group met at the University College provided free of charge, and one group met at a boarding room provided free of charge at a sports facility. Informed consent forms, summary of project plan, my personal card, paper and pencils were laid beneath each cover. The rooms were rearranged beforehand if necessary to reduce visual distractions (ranging from office equipment to plastic flowers and skeletons), audible distraction (closed windows due to traffic jam) and to enhance group interaction and recording.

Focusing and/or ice-breaking tasks

All participants were greeted with a handshake, and told to sit wherever they preferred (except in the places occupied by us). After serving coffee and suchlike, guests were encouraged to take a look at the informed consent form and summary we had handed out. Informed consent forms were signed in duplicate – one for the participant and one for the project. Even if the participants knew (of) each other beforehand, a research setting is somewhat ‘serious’. Many of the participants shook hands, even though they were befriended or acquainted. Practical schedules were revised before the session, including recording arrangements, the break, end of session, commuting schedules and so forth. These first minutes during which participants were welcomed, offered coffee, and asked to sign the informed consent form, serves several ends: ice-breaking, focusing by preparing a group of talkative and befriended participants for a change to the “research mode of discourse”. A round of introductions, where participants are obliged to speak, is recommended when the recorder is running. Participants stated their first-name(s) and age, and added a few words.

Running the group

The participants could sit wherever they wanted after my co-researcher and I had settled at opposite angles of the table. We chose this configuration because we wanted to emphasize

our wish to mingle with the participants, and that although we were partners we also had different assignments, meanings, experiences and roles in the setting.

When the groups met, all information was repeated. I reminded them of my professional duty of confidentiality, and that my co-hosts had accepted to be bound by a duty not to disclose confidential information obtained during the sessions. All participants were asked not to disclose sensitive information of a personal nature, and as far as possible respect the confidentiality of the other participants. The discussions proceeded without help after the aim of the study had been outlined, and we asked them to tell us about their first thoughts on being invited to participate in the study.

Recording the conversations

The group discussions were recorded on a minidisk recorder. The minidisk is very small, and almost disappeared on the coffee-table. It was turned on a few minutes before the participants were due to arrive, and turned off after we had distributed the gifts. Everybody was reminded that the conversations would be recorded, and asked to inhibit the urge to speak simultaneously – which in fact is what we do when we discuss without restrictions, especially when emotionally engaged. At the beginning of most of the group sessions we asked participants to speak for the sake of voice recognition, or later during the break if we had forgotten. Participants were asked to say their first name and age. Short phrases like “My name is Peter and I am 34 years old” turned out to be insufficient to recognize voices during the transcription process. We therefore asked people to expand their presentations in this manner: “My name is Peter. I am 34 years old. I am wearing a blue sweater and I am sitting next to you.” Our recordings range from 120 to 210 minutes, including some of the preparatory and debriefing conversations. Few if any of the recorded discussions can be described as “disciplined”. Rather than waiting their turn, everybody talks as usual – at the same time – making Babel of voices.

From recorded discussions to readable texts

According to several scholars, although transcribing interviews is a time demanding and exhausting enterprise, it is recommended to take this work load on. I have complied with this advice. Advisors should add that deciphering and transcribing “Babel of voices” is a

cumbersome, strenuous and time consuming task. The debriefing conversations with my assistants were not fully transcribed.

The sessions were conducted in Norwegian, and the transcripts have been normalised and edited in Norwegian (Norsk bokmål²³) before translation into English. Personal or local linguistic turns and expressions were kept when “translation” was impossible without losing the drift. According to Palmer, Gadamer advised his translators to concentrate on the argument in his German texts, and then rewrite the argument in the new language (Gadamer 2007). I have followed this advice. Commas, full stops, question marks and so forth are added some places to enhance readability. Laughter, silence and other sounds are indicated in the text in brackets (laughter), but not timed. Spontaneous interjections (comments and suggestions) are indicated by line break and name of speaker. Additional information to enhance readability or understanding is supplied in square brackets []. Round brackets () indicate omissions due to repetition, reference to other arguments, or to ensure confidentiality. In some places it is impossible to identify the speakers. This is indicated with a question mark ‘?’ instead of a name. In the group discussion we used participants’ actual names, replacing them with aliases in the transcripts.

During the time spent on transcriptions, field notes were taken as well. After every group discussion I made a memo containing notes from the diary, new ideas, reflections, forgotten topics or surprising reactions, notes on practical issues (attendance, location, running the group). Accordingly, the material is made up of eight working papers (one for each group), transcriptions of all eight group discussions including debriefing notes, and a separate post-session memo on each group. These memos are disclosing too much information about the participants to be attached. Substantial editing or rewriting would change their character too much to make any sense.

Immediate feedback from participants

All participants were asked how they felt about being in a single-sex group, and their immediate thoughts about cross-sex groups. Everybody agreed upon that cross-sex discussions are different from single-sex discussions, but not about whether they would have

²³ Bokmål is one of three written standards in Norwegian.

liked it or not. The female participants tended to be less eager, with eagerness diminishing with increasing age-grade, to participate in a mixed group, because they believed the presence of men would inhibit discussions, silence some altogether, and discourage people from telling stories. All said they had learned more about the impact of gender in physiotherapy and other health and social services. Some realized they were actually doing gender themselves, and most confirmed they had understood the aim of the study by the end of the session. The following quote from a one of the participants in preparatory session is illuminating: “When we leave, we have arrived at the point where we should have been when we came.”

The participants in ‘Gender sensitive rehabilitation project’ (GRS) met several times over two years. The quote cited above was first uttered in one of the GRS-sessions. Even though many of the participants knew each other from before hand (disability activists), had met several times within the GSR-groups and were familiar with gender perspectives and rehabilitation, this utterance came. When repeated in the preparatory session of *(En)gendering body politics* we all laughed, and wondered why we always had to start from square one. This experience suggested to me that it would be more fruitful to conduct 8 different groups one time, than to conduct 4 groups twice. I do not contend that this was the better decision; it only gives reason for the choices made.

Methodological considerations

Focus groups are a relevant methodical approach to answer the research questions of the study: ‘What do the patients *do* to negotiate enabling and constraining aspects of therapeutic encounters?’ However, the practical obstacles of recruitment, finding an appropriate time, date and location was arduous, as noted by senior focus group researchers (Krueger 1995;Morgan 1995). People more often than not have full schedules, independent of day to day variation in health and ability, and making room for a 3-4 hour appointment in the afternoon (including transport) was often impossible. I arranged for locations as close to the participants homes or workplace as possible, securing universal accessibility when required. Some of these locations were poorly suited as focus groups locations. Pragmatic considerations were necessary. I had planned for 6 participants in each group, and over-booked in case of dropout. Some of the groups had few drop outs and became too large (8 participants), some had too many drop outs, and became small (4 participants). In light of

experience I can see that the smaller groups made the best material for my study, and they had the quickest repartees and discussions. The group conducted at the sport facilities had the least appropriate room for the setting. We had been given a special treat, the board room, but this room was too big and “solemn”, it was a context for a meeting, not a conversation.

A regularly appreciated limitation of focus groups include the tendency for certain types of socially acceptable opinions to emerge (c.f. the propriety of any given social situation), and for certain types of participants to dominate. These constraints on talk do not invalidate focus groups findings; in fact it is these constraints that make them practicable and interpretable (Myers 1998:107). It need not be viewed as a problem if some of the focus group participants remain silent throughout the time. Silence is an enduring feature of human interaction, present in research communicative contexts, as elsewhere (Smithson 2000:108). A Goffmanian approach to silence reveals it as communication – either as attentive listening where the participant engage in the communication, or as a sign of contempt or of disconnectedness. When group discussions are audio recorded, silence is reduced to non-participation on the transcript. Accordingly, field notes from the group sessions ought to include comments on silent participants. Silence may be chosen, or imposed. In the transcripts, silence was only marked in the male C-group. This group stands out as dominated by a serious mode of discourse. Silence occurred after questions, followed by exchanges between the participants. Asgeir commented that the playful communication style that had dominated the other male groups where absent in this group. During our debriefing conversation, we identified substantial differences in age-grade (and gender on my behalf) as an obstacle. Another obstacle was probably due to their experiences with physiotherapy as “intimate”; treating injuries in the groin and buttock area.

Focus groups redistribute power between researcher and participants. However, Jowett & O’Toole contend that despite all their best intentions, they could only at best reduce and not eliminate such power imbalances. All knowledge is produced in someone’s interest so all knowledge is generated from positions of power/powerlessness (Jowett & O’Toole 2006:458). However, the notion of powerlessness and power is not straightforward. Implying that participants are situated as powerless does not acknowledge them as intentional and agentive human beings. Power denotes the range of available resources and means to reach an end. The participants have the means to attend or not, to engage themselves in the discussion by silence or speaking, and to choose which accounts to give and not. High drop

out rates and silence is well known pitfalls in focus group research. Personally, every group session was an overwhelming experience of powerlessness. My main resource, and recourse, was to place faith in and expect that all participants would go along with the scheme. However, even though the groups were assembled on my initiative, I presume all participants gained new experiences. These experiences are not available to me. This thesis only reports what I have learned.

Due to experience, I would recommended 4-6 participants in each group recruited from existing network or social groups, a venue with universal accessibility, a room (30-35 m²) possible to rearrange or “re-decorate”, and within acceptable range from major commuting systems. I would also suggest exploring and exploiting the intersections between tutorial groups and research groups, and create vignettes to get the discussions started. A learner-perspective on the subject matter and the interaction in the groups are most certainly a fruitful approach.

Goffman’s detailed lifelong studies in social interaction, the linguistic analyses of conversation in groups, and Gadamer’s lifelong pursuit in hermeneutics, leave the impression that a minor research project are unable to generate new knowledge unless the material is meticulously analysed along these or other lines. I acknowledge the huge impact of these analyses, but I am not capable of following suit. However, Gunzenhauser (2006) reminds us that the quality of qualitative research nevertheless rests with the quality of the relationships developed between the researchers and the researched as knowing participants (Gunzenhauser 2006). No methodological consideration can outweigh this issue.

Writing and reading

Writing qualitative research on health related questions touches upon the problem of communicating to a readership whose training and experience are primarily quantitative (Agar 2004;Belgrave, Zablotzky, & Guadagno 2002;Ellingson 2006;Malterud 2001;Malterud & Taksdal 2001;van Manen 2006). In addition, science in our western culture is highly regarded, and is more likely to be trusted evidence because of its numbers (‘hard’ facts), than textual interpretation and representation (‘soft’ facts). Numbers tend to talk louder than

words, and outdoes multiplicity and ambiguous reflections. This is a concern which occupied Gadamer the last decades of his life, as the subheading of *The Enigma of Health* suggests: *the art of healing in a scientific age*.

Writing is never done in a vacuum: an imagined reader is always present. There is a trade-off between giving too detailed and too imprecise a description of methodological concerns in the text. Most of the authors cited above, address the problem of how to represent focus group discussion in the written reports. They point to the fact that there is a tendency to omit quotations of actual conversation, and only include snippets from one participant at the time. I have complied with their request of including longer extracts. When the researchers' names occur in the excerpts, they are participants in the ongoing discussion. I was not the hub of any conversation, but along with the other participants, did my best to purport the establishment of a common ground, and to figure out how to contribute to this common ground. This is in accordance with a social constructionist perspective on focus groups where the social context is taken into account, as well as the learning-perspective on focus groups methodology.

The next section introduces the participants in the study (*En)gendering body politics*.

Research assistants, participants or guests?

How to refer to people who in different way have contributed to this study has been a recurrent issue. The issue was made problematic in the group discussions, and is made problematic by some authors on medical sociology. Talcott Parsons highlights the complementary role of the patients to the physicians (and other health care agencies), and call attention to Fox's construal of patients as research assistants as opposed to "inmates" on the ward where she did participant observation studies (Fox 1959;Parsons 1975:271). The patients acted as research assistants by way of self-observation and reporting to the researchers. The present study depends on the participants' self-observation, self reflection and reporting to the group, and as such to a certain extent qualify as research assistants. Even though acknowledging these argument I have settled on the generic term 'participants' to refer to the group members, and assigned the term research assistant or co-worker to refer to those who

were paid to participate in the groups. None the less, all those who have contributed have been treated as guest. The first interlude furthers this discussion on naming.

The participants were drawn from existing groups as recommended by several researchers (Kroll, Barbour, & Harris 2007;Warr 2005;Wibeck, Dahlgren, & Öberg 2007;Wilkinson 1999a). McLafferty argues that smaller groups (five or so participants) are more manageable and that groups made up of strangers require more moderator intervention (McLafferty 2004). He recommends creating groups that consist of people who know each other, in contrast to the usual advice that they should be strangers. In this study I have conducted 8 groups, with 4-8 participants in each group, a totality of 26 women and 22 men, aged 18-77. Each session lasted 90-120 minutes (the longer included a short break). Most authors recommend 60-90 minutes discussions, including warming up exercises. Tutorial groups are regularly 2 academic hours and a break. Preparatory discussions between me and my assistant, group discussions, and debriefing discussions were audio recorded, ranging 120-210 minutes recording. The collected audio recorded material make up 21 hours, including the preparatory session.

My aim was to invite, and create, different circles of shared experiences.²⁴ The participants are allocated to the different categories by self identification. Accordingly, the groups are the result of inviting people from already existing circles of shared experience; e.g. patient associations, sports teams, “friends of friends”. As a host, I began by thanking them for accepting my invitation, and briefly introduced the conversation topics. I informed them about my professional code of ethics requiring me to respect their confidentiality, and cautioned them not to disclose more than they wanted to, and reminded them that the conversations were being recorded electronically. All were asked to give their age and first-name to the other group members.

None of the participants were asked to provide information on their health, medical history, disorder, occupation or family life, either during the group sessions, to the organiser or to me. Furthermore, we did not ask how these people’s bodily functions are conceived by their physiotherapists or doctor. They were cautioned to be particular with disclosure. Self disclosure occurred, as will be seen in the following. Disclosure that might lead to identification of an individual are either omitted or changed. By participating in organized

²⁴ This phrase is borrowed from Arthur W. Frank 2004.

sport activities, swimming circles (hydrothermal therapy), membership of diverse health or disability related associations, or frequent contact with a medical equipment retailer/seller, the major frames were set. Increasing age often brings a diversity of problems and malfunctions, which is reason enough for some to seek membership of more than one health/disorder/disability association.

Marková et al (2007) remind us that every individual makes his or her world in terms of others by dialogically constructing and re-constructing the social world as multifaceted and multivoiced. To make a world in terms of other presupposes that no one talks at cross purposes. A research design grounded in an interpretive paradigm must be attentive to the questions raised and addressed by the participants. My assistants had been asked to get involved and participate in the conversation as much as they wanted to, while attending to my research interests as far as possible. Asgeir posed questions or comments utilising his experiences as a man, employee(r), father or husband – and bodily concerns. As an example he could highlight or downplay age or personal experiences in regard to the issue of interest to the participants – e.g. talking about middle aged spread or wifely concerns with participants in similar life situations, or calling attention to how men take pleasure in female caressing, the impact of age-grade, and the constraints of “political correctness.” Asgeir and the men in the ABD-groups shared vivid memories from the women liberation movements in the 70ies. With the young athletes, difference in age-grade was a challenge to both of us, but Asgeir could make some connections to ‘men & football’ that was impossible for me. Laila, as a disability activist, posed questions or made comments to the discussions drawing on her particular background and knowledge. She encouraged the women to tell about experiences (previously known to Laila) that were particularly relevant to my study. Arnhild and I both played our previous roles – Tobba the letting go part, and Arnhild keeping structure – and the opposite, interchanging during group sessions. Arnhild explicitly tried to involve participants that risked being “overrun” by talkative participants. Arnhild also contributed with more subtle food for thought questions regarding being a woman, mother, employee(r) or wife – and bodily concerns.

The four male groups were identified as AM, BM, CM and DM, and the female groups as AF, BF, CF, and DF. A brief presentation of the groups, the venue and attendance/withdrawal follows. The differences are highlighted, along with some of the questions they raised. All

participants are given pseudonyms. My assistant with the A-ladies and B-ladies is given an alias.

A-ladies, The Norwegian Association of Heart and Lung Patients

AF - held at a municipal health service centre, with eight women who showed up in good time for the scheduled session, participated. Seven had agreed to come, no one dropped out. All participants were members of or associated with the National Association of Heart and Lung Patients (Landsforeningen for hjerte- og lungesyke). We assembled around a table with a keyhole shape. The session included a break. The organiser participated in the group.

Alexandra (58), Annabel (61), Amy (61), Angelica (71), Augusta (67), Annie (70), Agatha (71) and Alice (75) are members of or affiliated with the Norwegian Association of Heart and Lung Patients, and are regular users of the therapy pool. The ladies in this group are particularly quick to laugh, and they constantly give in to collective laughter. Anecdotal reference was frequently made to a paradigmatic experience. Years ago there had been a male physiotherapist (PhX) in their City, who had very itchy fingers with his female patients. Alexandra related her experiences, and the others followed. Every time a story about PhX surfaced, or someone alluded to him, the group bursts into laughter. The group mentioned gender frequently, and how gender characterises and influences diagnoses and disorders, the conception of ailments, perception of prestige, and credibility. This group was also preoccupied with inefficiency and things they objected to in Norwegian physiotherapy, in comparison with retreats in the Mediterranean for convalescents. The latter was evaluated as the best, primarily because the therapists use hands-on therapy and don't disappear while treating the patient. Treatment is portioned out on a daily basis, the sessions are longer, the effect longer lasting, and last but not least, because the body is affected by the temperature, it is more receptive to therapy. Effect of treatment is considered to be "cost-effective" by the women.

Female research assistant (in her 60ies).

B-ladies, Norwegian Rheumatism Association

BF – held in a municipal health service centre, with eight participants who showed up in good time to the scheduled session. Seven had agreed to come, no one dropped out before we started, one left in the break (age 71). All participants were members or associated with the Norwegian Rheumatism Association (Norsk Revmatikerforbund). We assembled around a table shaped like a keyhole. The session included a break.. The organiser participated in the group.

Beatrice (63), Brenda (63), Belinda (70), Bonnie (66), Bridget (71), Britney (71), Beth (52) and Barbara (53) are members of or affiliated to the Norwegian Rheumatism Association, and are regular users of the therapy pool. The discussions were calm, sometimes reserved, and sometimes light-hearted and amusing. There was a lot of chuckling and laughter in the background, and the whole group burst into laughter on several occasions. Bridget left in the break, but she had not participated very actively before she left, and the conversation continued unabated after her silent disappearance. She was known to all, and to my knowledge tended to withdraw, and the rest of the group acknowledged her reasons to leave. This group is preoccupied with convalescence abroad and objectionable practices in physiotherapy, concerning interaction with their physiotherapist, inadequate massage and handling, caressing that does not make any difference, and how to “survive” on a waiting list. They are utterly dismayed by the lack of public interest in rheumatics and the disease’s low status. Convalescence abroad was discussed as it was by the A-ladies, with Norwegian physiotherapy being less appreciated and criticised more compared to treatment received in the Mediterranean. The women do not understand why the therapists are reluctant to provide “Mediterranean therapy” in Norway – what they are calling for in particular is hands-on and attentive physiotherapists. Treatment in the Mediterranean is too expensive in the long run.

Female research assistant (in her 60ies).

C-ladies, athletes

CF – held in a room at the University College, with four participants who showed up in good time for the scheduled session. Two more were expected, even though they had not actually confirmed participation. The organiser, a first year physiotherapy student, was asked to participate, to make up a group of 5 participants. To the best of our knowledge, she was still more of an athlete than a physiotherapist, and had experience of physiotherapy for sports related injuries. All participants were or had been ballplayers (football, handball, volleyball); one had switched to kickboxing a few years ago. They were all elite sportswomen. We assembled around a square table. The session did not include a break. We had agreed to end earlier than scheduled, but still include a break. However the discussions were very lively and the break was post phoned until it was too late. The organiser participated in the group

Carolyn (22), Catherine (21), Cassandra (21), Carmen (21) and Cindy (21) were friends of friends, and everybody knew Carolyn. They did not play the same ball games nor were they in the same teams, though two of them had once been members of an elite handball team and two others of an elite volleyball team. They shared being female athletes at or near the top. This group discussed the phenomenon of pain, and how to endure it without complaining, or seeking professional help for injuries. It was important to be tough rather than a sissy, and live up to the standards set by the men in the same type of sport. They also showed me how interaction with the team physiotherapist could be playfully sexualised and attentive. Qualifying injuries and preventing hypochondria were central aspects of their body politics. Fortunately, they had “Wailing Walls” at hand if necessary, and some argued it was a relief to subject their injured body to therapists who had nothing to do with athletics, where they could let go of their tough image. Body politics became a salient aspect of their experience as athletes and ordinary people. They had few if any experiences that suggested that gender – or biological sex – imposed constraints to their aspirations or life plans. Their account on the matter referred to contemporary commonplace understanding that equal opportunities independent of gender are achieved. These young women had yet to go through the “gendered” experience of womanhood, i.e. getting married, settling down, having kids, living a conventional or subversive life and so forth.

Female research assistant (aged about 40).

D-ladies with impairments and disabilities

DF – held at the facilities of a medical equipments retailer, with six participants who showed up in good time for the scheduled session. No one dropped out. All participants had some physical limitation or disability, two used an electric wheelchair, and two brought their own cushions. We assembled around a square table. The session included a break. One of the participants had participated in the ‘Gender sensitive rehabilitation’ project.

Daisy (35), Doris (28), Daphne (57), Daniela (42),²⁵ Diana (45) and Deborah (50) have all had their impairments and disabilities for at least seven years, and some considerably longer. Additionally, Daisy has a child with multiple disabilities. This all-female group was particularly light hearted, giving way to fits of roaring laughter, often collapsing with laughter, with individual members giving into bursts of laughter on their own, giggling and chuckling. The women in this group were not personally acquainted, but they certainly made up a circle of shared experience. Their personal narratives about pain, bodily vulnerability, disrespectful treatment, distrust and embarrassment were told collaborative and humorously. None of the narratives or comments was too small to be laughed at, and they all are laughed with one another, in a supportive and acknowledging manner. To the group pain was a palpable dimension of their lives. All treatments are painful, they dread the sessions, but keep to their appointments year in, year out – but needs must. The therapists’ sex was discussed lively, some preferring female, some preferring male therapists. The male therapists acknowledged the women, and did not interfere with their body politics, that is their bodily resource allocation or priorities, domestic work division and self-presentation. The female therapists also acknowledged their body politics, but talked about priorities, experiences and so forth, based on an intersubjective relationship between women. This group talked about giving oneself up to the therapist as a prerequisite for treatment outcome, and questions concerning body politics were raised recurrently.

Female research assistant (aged about 40).

²⁵ Participated in some parts of the Gender Sensitive Rehabilitation project, see chapter two.

A-gentlemen, The Norwegian Association of Heart and Lung Patients

AM – held at a municipal health service centre, with five participants who showed up in good time to the scheduled session. Seven had agreed to come, two dropped out, one of whom had informed us in advance. We had some trouble with the automatic locking doors, so there is a theoretical possibility that the last participant showed up, and did not manage to get inside or get in touch with us. One of the others had run into this man earlier the same day, and he was told that he would be joining the group. All participants were members or associated with the National Association of Heart and Lung Patients (Landsforeningen for hjerte- og lungesyke). We assembled around a square table. The session included a break.

Alan (73), Alec (61), Andrew (75), Albert (70) and Anthony (69) are members of or affiliated with the Norwegian Association of Heart and Lung Patients, and some are regular users of the therapy pool. Several of the men in this group were born and raised on small farms along the coast, and earned their livelihoods as craftsmen. They were friends, neighbours or acquainted as people are who grow up in rural areas. This group's discussion tended to be calm, humorous and good-natured, there were no complaints about pains or ailments, and they frequently joked about or teased each other. This group enacted heroic masculinities, enduring pain, being in control, and not complaining. They suffered from problems such as cervical disc protrusion or elbow tendonitis, shoulder pains, heart disorders, long periods without treatment, or periods of painful steroid injections, and so forth. Complaints would have been understandable. These gentlemen had lots of experience of non-effective physiotherapy, which they blamed on dubious methods and principles. One of them had been to Thailand on holiday, and the story he told about it prompted a discussion about gender, intimacy and sexuality, and convalescence abroad. The men teased each other, and teased and flirted with me (as Asgeir pointed out to me afterwards). This group's conversation made me more sensitive to the role of flirting and humour in creating a fertile ambience in which the conversation could evolve – an ambience recognisable in my own and my colleagues' work as physiotherapists.

Male research assistant (aged about 50).

B-gentlemen, Norwegian Rheumatism Association

BM – held in a municipal health service centre, with five participants, four showed up in good time to the scheduled session. All participants were members or associated with the Norwegian Rheumatism Association (Norsk Revmatikerforbund). Eight had agreed to participate. Due to the death of a close relative in my family, this group had to be postponed a fortnight on short notice. One of the participants had forgotten the new arrangement, but arrived after being called. Two were not able to attend on the new date, and one who had said he would show up dropped out without notification. At site, we spent some time calling members for this group, until we had group of five. The session started 20 minutes late, included a break, and ended 20 minutes behind schedule. All agreed to this. We assembled around a square table.

Brian (77), Bill (72), Bruce (54), Bernhard (67) and Benjamin (61) were members or affiliated with the Norwegian Rheumatism Association, and some were regular users of the therapy pool, where Bruce was a life-guard and caretaker. Bruce was still working, while (to my knowledge) at least three of the other four had retired. The atmosphere was light and friendly all the time, and though they talked about their ailments and bodily decrepitude, along with more or less successful therapy, there were no complaints. Some of them had experience of convalescence abroad including massage in Thailand. Differences and similarities between therapists from different nations and particular university colleges were discussed. Two paradigmatic experiences were recounted. One was about a female German physiotherapist who had climbed onto the back of a patient, and the other was about Thai massage. This latter episode prompted banter about gender, causing a certain amount of mirth. The men shared personal narratives and reflections, experience of alternative treatments and therapeutic principles, props and remedies. They laughingly admitted to a masculine perception of the body, working out and playing make-believe with their physicians, while their wives or their male peers got the complaints. These men also flirted with me; why did you bring a guardian (Asgeir) to come? Didn't you dare to come alone? Bruce is late because he has to brush up his appearance to meet a lady. You didn't need to bring sweet strawberries, 'cause we're sweet enough already. As with the AB-ladies and the A-gentlemen, they discussed instances of physiotherapy which seemed objectionable to them, and also made "cost-benefit" analysis of the effect of treatment.

Male research assistant (aged about 50).

C-gentlemen, athletes

CM – held at a sports facility, with six participants. All that had agreed to participate turned up, but some of them turned up much later than the scheduled time, and we had to search for some in the gym. All were top level ballplayers (football, handball). The session started 30 minutes late. We had agreed to take a short break during the session, but changed our mind as the discussion was particularly fertile and we had limited time. The session ended slightly behind schedule. We assembled around the half part of a huge conference table.

Conrad (21), Chuck (20), Carl (22), Clyde (20), Chris (18) and Charlie (18) play football and handball in the top echelons. These young men were preoccupied with building trust with their therapist, preferably an experienced male, heterosexual therapist. They sought help/therapy only when absolutely necessary, and injuries and complaints, often of an intimate nature (in the groin area, buttocks), were left to improve without outside help. They acted upon culturally mediated masculinities. Boys have to endure some pain and discomfort, and being a sissy is out of the question. They did not inform their trainers about injuries. Naming is framing, and these men made a particular point of using the right terminology: they are healthy athletes, not patients or “users”. The session was often quiet, with little laughter and teasing compared to the other groups. This is after all a half-serious occasion, as one of them said, in a pleasant voice. We were assembled around a huge conference table at a facility adjoining a sports ground, the board meeting room in fact. What impact the pictures of former victories, leaders and heroes on the wall made, I would not know, but it might have prompted the rather solemn atmosphere. My assistant and I were particularly challenged on the intersections of age and gender. Compared to these young men we were well on in age, and the differences in age and sex (an “old” female researcher in a heroic-masculine sports ground) became conspicuous. The athletes introduced us to the “changing room effect”, which might swayed this group. Changing room banter and mockery are particularly male gendered. When a woman enters an all-male setting, like a changing room at a sports ground, they all begin to behave themselves – and their verbal exchanges change in character as well. Male research assistant (age about 50).

D-gentlemen with impairments or disabilities

DM – held at the facilities of a medial equipments retailer, with four participants. Six had agreed to come. One gave notice that he would not attend, one was trapped in a traffic jam and gave up trying after 50 minutes, and one had forgotten and was unable to attend with only 5 minutes notice. Accordingly we only had three of a possible six participants. The organiser at the facility then offered to join the group since he had wide-ranging experience of physiotherapy, and he satisfied the other criteria for this group. All the participants had some physical disorder or disability, two used a manual wheelchair, and one an electric wheelchair. One changed to a regular chair when seated around the table. The session started 40 minutes behind schedule, but we did take a break, and ended half an hour behind schedule. We assembled around a square table. The organiser participated in the group.

Desmond (37), Duncan (42), David (32) and Donald (39) have all had their impairments and disabilities for at least a decade. A prominent aspect of the discussion involving this group was the particularly cheerful mood, giving way to fits of roaring laughter as well as lots of laughter and teasing, and lots of deeply personal and reflected conversations. There were no complaints about pains or ailments, but several stories about wounding experiences. The conversational style was amicable, despite the frequent teasing, interruptions and comments. Members of the group talked to each other, to me and my assistant Asgeir, not as strangers observing their conversation, but as ordinary group members. The banter and mockery were directed at one other and us and at themselves, often in self-mockery. The teasing and joking in this group was more explicit than in the male A and B groups. Gender and sexuality were rapidly introduced in the discussion, with examples of what it is like to buy contraceptives when seated in a wheelchair.

This group contributed profound insights in three main areas: the power of dialogue; the clinical touch; and the conceptualization of the body. The group addressed and highlighted the power of dialogue throughout the session. They do what they call the 'personal ad test' which enables them to sort out the foundations of a relationship, and figure out whether it is likely to work or not. As a part of this dialogical assessment, they pinpointed the importance of taking time into consideration. Minor physical problems which a few treatment sessions can fix were never subjected to the same scrutiny as long-lasting relationships with therapists. Second, the group introduced the concept and practice of clinical touch, and discussed its

implications for personal wellbeing and outcome of therapy. The meta-communication through touch – ranging from appreciation to disgust or loathing– was also addressed. This group discussed how the body is conceived in terms of performance and achievement – i.e. naming and framing as disabled – and the implications for self-awareness and ascribed abilities and characteristics.

Male research assistant (aged about 50).

Engendering difference

The participants in this study comprise 20 men and 26 women. They differ along a number of social dimensions, personal preferences and characteristics –biological sex, age, ableness, education, occupation, place of residence and childhood environment, family, urban/rural attachment, economic status, social class, health status, dialect, attire and so forth. According to Foucault the mere act of enlisting differences that subsequently can be used as a means to segregate and label people is a discursive practice, or in his words, discourses are ‘practices that systematically form the objects of which they speak’ (Foucault 1972:49). If naming a difference is to create or reproduce the same difference, it ultimately constrains any attempt to describe it without circumscribing the issue, or rethinking the concept and idea of ‘difference’. My groups *are* different, and the participants *are* different, but none of the differences listed above make any sense alone – they intermingle, as it were, and why and how they do so is related to time, place and social actions, or the person’s situatedness. However, openness to difference, is important, as long as the difference not is created as a new centre of a new web. The aim is not to explore the difference as such, but inquire about what the difference does or engenders in social life. In other words, to access socially shared knowledge on the issue – and be able to articulate folk models of bodily concerns and agency.

Focus groups are talk and interaction, where we literally talk gendered difference into being (Crawford 1995;Goffman 1959;Goffman 1981;Martin 2003;Martin 2004;West & Fenstermaker 1995;West & Zimmerman 1987). A single woman in a group of men might change the gendered language or be “muted” by it. Bringing an associate researcher helps redistribute gendered power or tension. A male associate in the male groups constructs a “bridge” between a socially acceptable, ignorant female researcher and an all-men language-use and all-men experience, as well as constituting a ‘male commitment’ to the aim of the study. The female groups almost invariably were sceptical to the idea of a male researcher in an all-female group. But had we tried it, it might have turned out successful. This study did not have the means to pursue these strands.

In *Talking Difference*, Mary Crawford addresses the vexing issue of sex differences in a critical examination of studies devoted to uncover sex differences in men’s and women’s

language-use (Crawford 1995). Crawford's arguments further illuminate Foucault's concept of discursive practices. Her point of departure is gender in relation to language, but her arguments are applicable to any social category. Crawford lists four limitations of focusing on (gender) difference:

i) Making a distinct difference between e.g. ability and disability, women and men, young or old, construct them as opposites, even though they often have much more in common than different. Focusing on disability (or black skin, women) implies that ability (or white skin, men) is the more important social category. An identical match in "situatedness" is impossible to find, since the able (or men) and disabled (or women) are met with different social expectations and reactions. In some sense difference-research creates the very differences it seeks, and reinforces normality.

ii) Difference distracts attention from issues of power and dominance, what appear to be a difference of sex, ableness or age, may instead reflect linkages among gender, status and power; e.g. oppressive practices towards people with a disability can be construed as essentialist characteristics embodied in persons with a specific biological sex, disorder or ability.

iii) Focusing on one difference makes everybody that is labelled a unitary category – all men, all disabled, all well on in years. People differ from each other in numerous ways. Foregrounding biological sex as the most important difference, or ableness, moves other differences into the background, and intersections are impossible to detect. Making everybody alike – e.g. all men – obscures alterity.

iv) The difference approach treats the difference as a fixed, static attribute of individuals, and minimizes or overlooks the importance of situation and context. It is an essentialist approach that views gender, or disability, as a fundamental essential part of the individual, that determine roles or actions.

Engendering difference is not a problem as such; it's a recurring part of any social occasion. The theoretical underpinning of the present study is well suited to deal with these issues.

Closing remarks

This chapter reviewed and discussed focus groups as a research method, and gave reason for the choice of this method for the present study. In this study focus groups are construed as situated social gatherings, where people meet face-to-face and mutually and immediate interaction occur. The situation at large gives behavioural clues, i.e. the larger social context sets boundaries for what the group are able to discuss, and how the interaction evolves.

Employing Goffman's and Gadamer's perspectives on interaction and understanding acknowledge the fertile potential in the ever changing interplay between the participants; interruptions, silence, laughter and disruptions in the researcher's schemes. The concept of play in critical hermeneutics embraces this style of communication.

The next chapter is an interlude which recapitulates the aim of the study and the research question, and addresses one aspect of how the participants negotiated the premises of the study.

Interlude

To recapitulate; the aim of this study is to inquire into patients' experiences to gain knowledge about possibilities and constraints for recuperative encounters with physiotherapists, and to learn how they conceive of and enact health and illness. With particular reference to gender, the study seeks to identify resources that can be used to make new purposes possible. The following chapters are presenting some answers to the research question: What do patients *do* to negotiate enabling and constraining aspects of therapeutic encounters, with particular reference to gender?

Before I turn to the empirical chapters, a problem indicated in the last chapter on methodology will be addressed; the issue of how to name – and accordingly frame – the participants in this study. The section below recapitulates this discussion, and gives reason for my choice of *patient* and *participant* as generic terms in the thesis.

Naming and framing

Naming *is* framing, an issue explicitly addressed by the C and D-gentlemen. When a person makes an appointment with a physiotherapist, the therapist subsequently refer to her or him by personal name and/or a category denoting the relationship between them. Categories have several layers of meaning, their common usage and institutional and historical references. In other words, the relations between people or props or edifices or other resources are implied in the category applied. We cannot life without classifying and being classified (Christie 2005;Goffman 1983;Goffman 1986). However, we have a moral plight to pay attention to how these classifications and categorisations ring with those they are ascribed to, and which interpretive schemes they evoke.

The user participants in Wilkinson et al.'s study of service user involvement in medical education, many of which had experienced lengthy periods of poor health, engaged in animated discussions of whether they liked to be called service users, patients, clients or consumers (Wilkinson, Rees, & Knight 2007). Interestingly, their study as the present one, did not address this topic explicitly from the outset. However, these discussions emerged when experiences from diverse health and social care agencies were evoked.

The participants in the present study can be named and framed as patients, clients, users, citizens, customers, guests, and partners – and more. All these words have been recognised as ‘politically correct’ in their ‘time’ to describe the health agents’ ‘other’. The same goes for the words invalid, handicapped and disabled; they were thought to be ‘correct’ and precise descriptions of the persons to whom they were ascribed. In my study there are people that have had the dubious pleasure of being identified by all of these labels, or “disorder-labels”, their personal name exchanged for their medical disorder or diagnosis. However, they are also students, clergy, academics, craftsmen, businessmen and -women, teachers, nurses, lawyers and so forth. Naming a person as a middle-aged businessman creates a different associative frame than naming a person as a young, unemployed, single mother. The frames craftsman, cleaner and director evoke different interpretive schemes and social expectations. These positions give off different symbolic meanings, different resources at hand, and different prestige – and they assume gender. The names and frames used outside the health care frame are imprinting the conceiving of health related challenges within the healthcare frame, as do the labels we apply. My reflections on this topic are only touching upon the matter. However, I remark that the labels we use about *them*, also speak of *us* – and of the *relationships* between us.

The term *athlete* speaks of different relationship with me than the term *patient*. An athlete probably needs me as an audience, providing acknowledgment of her performance, but an athlete can do a lot without an audience. An audience demonstrates its approval of the athlete’s efforts, watching and shouting, a literal touch is seldom possible or appropriate.

The term *patient*, however, is meaningless without its ascribed Other, a provider of care and cure, or at least consolation and advice. The patient’s Other is most often a professional, one who is given legitimate access to our bodies, by the power devolved to the professional and the institutional bodies. The patient is the subordinate, the professional the superior.

The term *user* does not ring easily with activists, or with me and many other professionally trained healthcare workers or researchers. It has been widely criticised, and is exchanged with the term *citizen* in the polity area (Ministries 2001a; Ministries 2001b). Justification of the critics differs, of course. I use my computer and my car, without giving a second thought about reciprocity, or dwelling upon refurbishing, rearranging or changing these props. Living

people, however, cannot be used in the same manner. Even playing upon strategic essentialism, playing disabled or a poor little blond to increase outcome, is not a way of using fellow men and women – it's a play – where cheating comes in handy. Therapy is, one way or another, the result of two persons' efforts, and hence it is impossible to use the other. Abuse however, is always a possibility.

The term *citizen*, the contemporary recommended one within the healthcare politics, is supposed to encompass everybody, as a domiciliary principle honouring democratic rights, but is seldom used publicly about non-marginalised or non-discriminated people. It is based on an ideal non-oppressive professional practice, especially vis-à-vis people living with disability or who are otherwise marginalized. Accordingly, the connotations make the concept 'citizen' relational and patient-like – you are in one way or another dependent on others, on a particular form of social interaction and structural adjustment, as universal accessibility.

The ethical challenge, however, is a petition to reflect the implicit symbolic meaning, the sedimented experiences and constraints, that follow the concepts we use to describe the Other– whether we concur and reproduce, or rebel and subvert. As a suggestion, the term athlete is often valued as a positive category and position. It tells of the self-made as well-made woman or man, of stamina, determinism, independence, and is given high prestige and status in our society, a cognate of appreciated masculine ideals. The term citizen (as patient) is often dreaded as a category and position; it is a label ascribed to the poorly self-made woman or man or to people suffering from misfortune and ill-health, those who need others to take care of them, and who have low prestige and status in the healthy society. This is a short and apt description, a caricature, but worth considering. And it is a reminder that the experiences of the participants in this study were gained when enacting the *patient role*, a role each and everyone will inhabit during their life: we are all former or future patients. That label, however, is never more than one of hundreds of labels that can be ascribed – to anyone.

Most of the participants in this study were invited to comment on the concepts and terms used to describe them. Doing this study, I listened to many people, some of them calling themselves handicapped or invalid, some patients, users or citizens. I was faced with the challenge to detect which category each and everyone preferred, and to act accordingly. Using the wrong term may destroy a volatile relation, and impart prejudice or preference not

intended. Or it may prompt dialogues expanding on the issue of naming and framing if mutual trust is established beforehand, and no one talks at cross purposes.

Tobba – (...) I get a bad consciousness when I call you patients when I take a glance at NN she calls herself a user I heard, but my colleagues call you patients when you attend them, what are you calling yourselves? Patients, users, customer, or what?
All at once – NN is a user, she's more into it, you know it NN!
NN– I know a lot of people resist being called patient, because it increases distance, sometimes I use a therapist, other times the therapist uses the plumber, so everything is user to me, but when I'm a patient, then I'm bedridden and ill
Tobba – but a user when you need services without being ill

This short excerpt illustrates NN's personal preferences. NN is a *user* whether it is a physiotherapist or plumber who provides the services. If she is a *patient*, then she is bedridden and ill. The others are content with or indifferent to the label patient, whether used by themselves or healthcare providers.

The male athletes do not think about themselves as patients or users, they are *athletes*. The term *patient* carries frail connotations for them, as for NN above. Still, physiotherapists are healthcare workers to them, even if they offer a kind of bodily service. A comparison was made between a car in a Formula 1 race and a patient, which construes physiotherapists as part of a maintenance team and 'healthcare workers light'.

Conrad – I don't know, I reacted to your 'patient' a few minutes ago, I've never thought I was a patient if I sprained my ankle or something, patient gives off frail connotations
(...)
Clyde – user, maybe
Charlie – injured athlete, restrained or injured
(...)
Carl – our injuries are mild compared to others'
(...)
Carl – they (the therapists) are health care workers to me, but not as much as nurses and physicians
(...)
Charlie – it's more like, maybe it's stupid, but imagine, a Formula 1 racing car, after a few rounds the tires are worn and need replacement, you drive into the pit-stop, they change your tires, and you're healthy again, they offer a kind of service, it's hard to find the right words
Chris/Tobba – service
Charlie – yes
Asgeir – a part of the team
Charlie – yes

The cutting edge in academic identity politics, special interest organisations and grass roots opinions overlap and nurtures personal opinions. The intake to the discussion below was a slip of my tongue, calling the participants disabled, and I was immediately corrected by Desmond.

Tobba – (...) from childhood to adolescence to a grown man, when you get disabled in early years (...)

Desmond – there you touch upon something when you say disabled, I'm not disabled, but I have a disability

Tobba – it's hard to pick the right words, because where is it, is it disabling boundaries and limits

Donald – it's the society that makes you disabled

Tobba – yes

Desmond – I see your point

(...)

Desmond – I think it's improving, it's better than it used to be, but it depends on the context, which challenges you face, if I had a job and signed as disabled bank executive, then the focus was quite misplaced

Lots of laughter

Desmond – I don't suffer all the time, or have a handicap, I can say handicap, but I don't focus on it, but if you ask me to run a particular distance, then I am disabled, but if we just move over, then it's no problem

Tobba – just like gender, sometimes it's relevant, sometimes it isn't

Desmond *is* not disabled, but he *has* a disability, it is societal structures that make him *disabled*, which Donald confirms by calling attention to the disabling barriers in our society. Desmond elaborates further on his contextual stance. He has no problems whatsoever with terms like handicap or patient if they are used in the proper context. As an example he suggested he signed his professional letters with 'disabled bank executive', which elicited lots of laughter from all of us. Disability and gender are particular social frames, which sometimes are made relevant as resources or barriers.

David has experienced that healthcare personnel are eager to frame him as *disabled*. They literally want to *frame* and *name* him by offering assistance and material resources that confirm and confine him as disabled, ordering him as *lacking* in Moser's construe, creating a lack the service system can compensate by means of props and service (Moser 2003). David experiences this as a provocative agency. Krokan & Heglum coin the term 'handicap education' in their new book on deliberate discrimination and offence against people with disabilities (Krokan & Heglum 2006). People with disabilities are socialized into a sick role, whereas able-bodied people are allowed to be healthy, they argue. In the light of this

conception of *disabled* as synonymous with *sick*, I ask David if he is given permission to be healthy, or is doomed to be sick.

David – I want to tell you something, there's a certain kind of people who are particularly preoccupied by making us disabled, and those are health care personnel, they insist on putting us into those frames, and if I say I don't need that service, then they tell I have to!

Tobba – but do you have to be ill at the same time, or are you permitted to be healthy?

David – my experiences are like in the office hours, then I must be ill, but when they are off duty, then, in a way, it doesn't matter; thank you! (Thumps the table)

David's comments summaries this section: How you conceive the Other has an impact on any social encounter.

Talcott Parson's construed his ideal typical sick role during the 1930ies. Forty years later he reconsiders the sick role and the role of the physician, especially the problem of the symmetry/asymmetry in the role relations between sick people and therapeutic agents (Parsons 1975). First he recapitulates the three primary criteria of accepting the social role of being sick; i) asserting that a state of illness is not the sick person's fault, ii) a claim of exemption of daily obligations and expectations, and iii) seeking help to avoid the undesirable condition (ibid.:262). Parsons presumes these characteristics still hold true. In his address he suggests a new behavioural image to get a grip on the asymmetry between the sick and her health care agents; namely the student-teacher relationship in higher education (master's level and above). Academics and physicians represent institutional superiority, and occupy roles characterized by fiduciary responsibility. Parsons further the argument to include the parent-child relations (ibid.:277), and as such tie into Goffman's argument on the gendered asymmetry (Goffman 1979). I have settled on the term patient due to the health agencies institutionalised superiority and juridification – and to remind readers of the rights and plights accorded to any patient.

What follows are different windows to talk and interaction in physiotherapy. In chapter five to ten the main currents are conversation and touch, and how this is enabled or constrained by the social context or the interpretive schema at hand. These two phenomena too a large extent determine how the participants conceive of the encounter at large, and the recuperative potential in therapy. Even though they are intertwined in the group discussions and in real life situations, the issues of dialogue (chapter 5), touch (chapter 6), self presentation (chapter 7),

gender (chapter 8), pain (chapter 9), and agency (chapter 10) are dealt with in separate succeeding chapters.

5. A dialogical point of departure

This chapter is presenting the significances of spoken interaction in physiotherapy.

Physiotherapy is a social occasion where two persons are in one another's immediate presence, an occasion constituted and sustained through talk and interaction, and through talk as interaction. Talk is an example of an arrangement where individuals come together and sustain a situation having a ratified, joint, current and running claim upon attention, a claim which lodges them together (Goffman 1981:70-71). No resource is more effective as a basis for joint involvement than speaking, Goffman contends. Words are the great device for fetching speaker and hearer into the same focus of attention and into the same interpretive schema that applies to what it thus attended (*ibid.*). Every thing that can be understood is language, Gadamer adds.

Decision making in physiotherapy, whether jointly or by the therapist alone, presupposes that some knowledge about the patient's bodily concern is made available to the therapist, and that the therapist is capable of understanding what the patient tries to convey. This knowledge is initially provided through speaking, a conversation between the patient and the therapist, or by proxy. Further more, physiotherapists gain knowledge about the patients' concerns by concrete handling of her or his body. Whereas Goffman talks of joint involvement, Gadamer talks of understanding. Gadamer's point is that the dialogue or conversation is a basic model of reaching an understanding together (Gadamer 2006c:51). The dialogue is spoken words and non-linguistic gestures – as both Goffman and Gadamer notices. Hermeneutics is primarily a practice, Gadamer argues, it is the art of understanding and of making something understood to someone else. Hermeneutics is at play when therapist and patient meet. In it, what one has to exercise above all, is the ear, the sensitivity for perceiving prior determinations, anticipations, and imprints that reside in concepts (Gadamer 2007:21). Gadamer's exercising of the ear is a phrasing carrying the same meaning as Goffman's claim upon attention in a joint situation.

Talk and conversation

The participants in this study repeatedly call attention to the importance of conversation in therapeutic situations – whether spoken words, gestures or bodily communication. The short extracts below present some of the constraints on dialogical interaction identified by Desmond, Annabel and Alexandra:

Desmond – but it's obvious, the talk and the conversation, it's different, if the treatment last for 45 minutes (implies a present therapist all the time), or the therapist runs around in 45 minutes

Tobba – then there is no room for long and winding thoughts

Desmond – no, no

Annabel – I've been to a female therapist, and I think they wander around too much, attending to this and that

Tobba – to and fro?

Annabel – then, you see, they can't stand beneath you and work

Alexandra – no, they can't, but that's why we're there

Desmond, Annabel and Alexandra articulate their claim on attention, and illustrate that the social occasion of 'physiotherapy' disrupts when the therapist leaves them. Every time the therapist leaves the patient to attend to some other patient or business, patients must pose new claims of attention. *Phronesis*, Gadamer writes, is awareness appropriate to the situation, where treatment, dialogue and the patient's participation comes together. It is a particular attentiveness, an ability to sense the demands of an individual, here the patient, and to respond to those demands in an appropriate manner (Gadamer 1996:138). The participants' comments above illustrate some of the structural and practical constraints to *phronesis*. An attentive presence or a dialogical interaction is illusory if the therapists are constantly on the run to meet other commitments. There will be no one social occasion, but series of minor meetings.

The A-ladies group, to which Annabel and Alexandra above belong, articulated their demands and anticipations regarding talking in therapy situations.

Agatha – when you see them first time, they could tell you, what they do, what they treat

? – my therapist is telling me, he starts careful, because you don't know what you're up against first time

Angelica – you don't know what you can take either

? – but still, I would appreciate some more talking

Angelica – it reduces your scepticism

Annie – I think it improves; the newly educated ones are cleverer
Alexandra – yeah, remember that doc looking only at his pc,
Everybody at once – it’s hopeless
Alice – I agree with Agatha, they must use some time in the beginning, explain; ask
next time, how are you doing

In his radio lecture in 1970 Gadamer states his general thesis on language and understanding, that reaching an understanding is a process that must succeed or fail in the medium of language (Gadamer 2006c:13). The ladies are alluding to the idea that mutual understanding is possible – if a conversation can be established. The Gadamerian dialogue pertinent to physiotherapy is the therapeutic dialogue, which aim to attain a particular goal – namely help healing processes to evolve, so the patient can regain health. It’s an attempt to set in motion once again the communicative flow of the patient’s life experiences and re-establish contact with others from which the person is so tragically has been excluded (Gadamer 1996:138). The excerpts above, to my knowledge, do not intend “tragically excluded” connotations. However, they are referring to a poorly developed communication situations where the non-linguistic events are incapable of acting as moves (Goffman 1981:71). Talk should be full of twists and turns, like a gamelike back-and-forth process which might better be called interplay than dialogue, Goffman argues. The ‘dance in talk’ might be available to us, and we could attend fully to what it means to be in play (ibid: 73). Every conversation can raise itself by its own bootstraps, as Goffman pictures it, and also provide its participants with something to fail at. The A-ladies and Desmond’s utterances imply that a therapeutic dialogue or dance in talk is always possible – as failure is. Speech immensely increases the efficiency of a collaborate task, as engaging jointly in therapy, being especially critical when something doesn’t go as indicated and expected (Goffman 1983:3). When patients are deprived of speaking with their therapist, the situation at large is at risk.

Trying to work out a situational definition

Any social occasion is situated in time and space. The situational aspects refer to the part that could not occur outside the situation, and which have its own rules of conduct or proprieties (Goffman 1963a:23-24). When therapist and patients meet within the confines of a therapeutic setting, a focused interaction is anticipated. Both parties attend to the situation, and both are obliged to “come into play” and to stay in “play” until one of them can leave the situation officially. A kind of interaction tone must be maintained (ibid:25). Below, Angelica

and an unidentified lady tell us what happens if the patient tries to raise a conversation by its bootstraps:

Angelica – but I've learned to ask, before they do something, why do you ask, they say, I ask and then I get an answer, unless they throw me out

Laughter

Tobba – you have to take on that risk

? – I had a doc in City for 12 years, and when I asked too much, he showed me to the door

Tobba – did he ask you to come back another day?

? – no, I never put my feet there again

Angelica had earlier on told the group about an unpleasant treatment situation, where the therapist used some of his mechanical props on her back, and her feet collapsed beneath her in the stairs when leaving. The therapist had not invited her to any therapeutic dialogue, and she still didn't know what kind of treatment she had been subdued to. An unidentified A-lady had been ejected from her doctor's office, because she asked too many questions. Angelica and Alexandra changed doctors and physiotherapists because of this kind of miscommunication. The group of A-ladies agree that violation of personal boundaries is legitimate reasons to change providers, as is a refusal by therapists to talk with them, or if their preferences are ignored. However, the challenges of finding a new therapist, prompts most to measure cost against benefit. The scarcity of therapists to choose from, having to sit on a new waiting list, and getting to know a new therapist or doctor, may turn out too cumbersome. None of these women told about life-threatening diseases or unbearable suffering. However, their experiences resonate with the stories of ill people in Frank's book on generosity (Frank 2004). One of his peers in suffering speaks about surviving cancer as the easy part (a part known to be extremely tough), and surviving the cancer centre the hard part. Angelica's utterances refer to an experience of painful treatment with an electric machine, which was applied without any verbal introduction. This was about 'surviving the therapy centre'. She was scared by the treatment and the fact that her back and feet gave way under her afterwards. The unidentified A-lady has a similar story to tell, of being denied verbal interaction by her regular general practitioner, GP. These women try to establish a dialogical relationship with their therapist or doctor, where both parties engage in creating a mutual understanding of the bodily concerns of the patient, and the situation at hand.

The story Doris tells, alludes to *phronesis* and therapeutic dialogue. Doris's new therapist greets her hospitably, they engage in small talk, he recognises her desires and demands,

worries and needs; he offers both acknowledgement and consolation. He listens. This extract illustrates the therapist's presence.

Doris – I've just started to see a new therapist and he asked, 'how do you Hoover up?', and I almost cried (*group roaring laughter*), what am I doing when I'm vacuuming, and there he was, right in the bull's eye, the things that matter to me, what I want to accomplish, even though he was a man

Her eyes fill with tears as she recounts the experience, and the group gives in to roaring laughter. In the presence of others, we become vulnerable to their words and gestures, as they become vulnerable to us. Being tearful might reveal the vulnerable and volatile self, as well as the precious self; how she precariously creates a way of living with her bodily problems. Laughter from the other group members can be interpreted in several ways. First, it can highlight a shared experience concerning the demands of daily living on women with physical disabilities or complaints. Second, laughter evokes an acknowledgement of a shared perception according to which a 'proper' woman still manages to keep house. Third, laughing shows agreement about the inability of men to recognise the necessity of vacuuming, and how much of a physical strain it is. In this case, laughter can also be interpreted as the support of group for Doris's personal agenda, her being able to keep her house in order despite the high cost. And it can also signal a collective ridiculing of the cultural expectations to women. Finally, each of the participants may be laughing of different reasons – any of the one sketched above, or another. Complying with group behaviour tells nothing of the reasons for doing so. Doris herself gives the therapist credit for recognising her need to manage her house. The case of laughter as communication will be especially developed in chapter eleven.

In a Goffmanian interpretation, the therapist applies his previous experience with patients roughly similar to Doris, and well used or new stereotypes about women like her to establish a situational definition. As a non-professional, posing questions about hoovering up takes its bearing from cultural expectation to women, e.g. to do the household chores, including hoovering up. As a professional, on the other hand, Goffman's multiple elaborations of how stereotypical schema is put to play in face-to-face encounters make more sense (Goffman 1959; Goffman 1964; Goffman 1983). The therapist probably knows from experience that hoovering up is particularly strenuous to people with her disability. Doris's interpretation lends support to this.

Disturbing or demanding guests

The group of C-gentlemen (athletes) reflect on the issue of national customs and the issue of having a disturbing or demanding guest in Frank's vocabulary (2004).

Charlie – it must be difficult, having a patient that is cheeky or rude, to differentiate between being a therapist or a private person, if the patient lacks manners, it must be hard to be professional, and keep on rubbing

Tobba – yes, and it is difficult to know what to do, endure or object, that is the same if anyone tries to abuse the relation, so, how much are we obliged to take, and how to make the boundaries visible?

Carl – it's individual what people reckon as flirting, what's right or wrong, and some would think that a flirting ambience is good, but there are certain limits were it's better for the treatment not to be flirted with

Tobba – fluid boundaries?

? – yes

Tobba – but flirting can make a boring task more pleasurable, right??

Carl – there are no boundaries

Charlie – there are no keys

Asgeir – it must be experienced by the one present

Charlie – you must know the other person well, know the others boundaries

Conrad – the therapist must be sensitive to the others signs to avoid abuse, the patient is the most vulnerable

Tobba – yes, the therapist is at work, it is the frame

Clyde – the therapist must take on the responsibility to stake out the boundaries, the patient doesn't know the practice, he's in for treatment, how would he know, if it's a rare occasion?

Physiotherapists make their living in face-to-face situations. Some of the meetings are more challenging than others, as Charlie implies. From the therapist's point of view, some patients behave rudely and discourteously; they agitate their surroundings like an unwelcome guest. They don't comply with the proprieties of the situation, in Goffman's words. Charlie call attention to the problem of drawing boundaries between a professional and non-professional response to such behaviour; involving the negotiations implicit in getting to know each other, and working out a definition of the situation. I ask them for their advice about how best to get through these negotiations. The group of C-gentlemen suggest the adoption of more fluid and porous boundaries separating the private and professional, while underscoring the structurally unequal (power) balance between therapist and patient. Only the patient and therapist can settle their scores, within reasonable limits. The one, the physiotherapist, acts as a professional, and has to guard the boundaries set by ethical, legal and professional standards, and acknowledge the patient as the more vulnerable of the two. An average patient would not know where the boundaries are supposed to be, Clyde argues. Sometimes a playful teasing, mockery or flirting interaction is supportive of therapy, other times it is counterproductive.

Clyde's remark reminds us that before the therapist and patient become more acquainted, the patient is at the therapist's mercy, and has to manoeuvre between compliance and negotiation.

The therapist has to exercise her or his ear, literally speaking, and pay attention to the patients' claims. However, both therapist and patient are vulnerable in each others presence, and both parties have to pay attention to the others claims.

Fluid and porous boundaries – setting the scene

Physiotherapy is face-to-face encounters, and body-to-body encounters. Following Goffman, we can participate in social situations only if we bring our bodies and their accoutrements along with us, and this equipment is vulnerable by virtue of the instrumentalities others bring along with their bodies. We become vulnerable to others, as they become vulnerable to us (Goffman 1983:4). In other words, we are vulnerable bodily subjects in any social encounter.

Physiotherapy is engendered and enacted as a social encounter in a particular setting. Conrad shared his strategies about dealing with volatile boundaries. According to Conrad, you trust the therapist to be professional, or at least you con yourself in believing they are professionals, and presume that no one thinks or acts in any sexually uncomely manner. This makes it possible for the patient to drop his pants, he tells. Following Goffman, people comply with social interaction arrangements for a wide variety of reasons, and one cannot read from their apparent tacit support of an arrangement that they would resent or resist a change (Goffman 1983:5). The situation demands of the participants that he gives the therapist physical access to his body. Accordingly, any violation of the non-abuse codex, paradoxically presupposes that the patient complies with the arrangement of accessibility. Charlie's advice tells of the same – you have to trust that the therapist comply with the proprieties of the situation.

The confidence patients place in their therapists takes its bearing from institutionalised superiority and fiduciary responsibility (Parsons 1975), and generic socially accepted conduct, which implies non-abuse of intimate situations. Past experience with the therapists or the patients' impression of the therapists outside the therapeutic frame – as a spectator at

matches, a participant in training or as a travel companion – builds trust or nurtures suspicion. All of which are non-present carriers of impressions and signs according to Goffman (1959). Getting to know each other aligns the power imbalance, and lowers the threshold for seeking contact. Accordingly, you dare to ask questions you would not ask “strangers”, Charlie contends. A *modus vivendi* is established, a working consensus on the situational definition (Goffman 1959:21). Matters outside the situation can be brought into the situation, and dealt with.

Being together with one’s therapist or obtaining ‘real’ information about their private life is not an option for most patients. Athletes who are signed up with a team which can afford their own therapists and people in small, rural communities often get to see more than the professional side of their therapist. One’s impressions are obviously coloured by the therapist’s demeanour and personal displays in his private life, and might serve to enhance or undermine one’s confidence in the therapeutic relationship, and/or affect one’s presentation of self within the therapeutic frame.

A talking situation – a working consensus

One of the benefits of knowing the therapist, the male athletes agreed (C-group), is that it makes it easier to establish a joint situation, to ask questions and air one’s worries. It eases small talk. When the participants manage to establish a definition of the situation, they have reached a working consensus, in Goffman’s terms (1959:21). Bernhard argues, that to him, the talking is less important than the doing in therapy, but nevertheless laughs when he recalls how he was given headphones and told to listen to music and calm down. The group laughs with him. Headphones might serve as a tranquilizer, but also prohibits dialogue and small talk. Bruce tells that he appreciates knowing that he shares a common interest with his therapist. It establishes mutual trust, and Bruce can air his fears or worries in a non-threatening environment.

Bruce – (responding to Bernhard’s utterance about headphones) then you’re unable to talk, about fishing or anything, if you have earplugs and music, but I don’t know if it’s a weakness I’m uncovering, but I find comfort in the possibility for small talk, whether fishing or other things, because then you dare to reveal your worries or thoughts, that’s common, we are thinking and worrying: is it stupid to think like this or that, but when you arrive at a talking situation, then I think it would be common, men or women alike, that we dare to uncover (...) I’m so worried about, I wonder

about this and that, and I think this or that makes it easier (...) I think it eases when you can talk about other things, like fishing or other common denominators, then you dear to unburden yourself, and I think I would have the same anxiety towards both male and female therapists

Tobba – there has to be something in common first?

Bruce – yes

Asgeir – trust in them

Bruce – yes

Bruce tells us that he does not reveal his vulnerable self or body to people he does not know well. He needs regular bouts of therapy to keep working, and the effect is heightened when the sessions give room for talking. Bruce's relationship to his therapist makes it possible for him to call attention to matters sited outside the therapeutic frame, and still sustain therapy as a collaborative task. His bodily signs and utterances probably act as moves in the dialogue, creating a Goffmanian 'dance in talk', or the Gadamerian being played in the conversation. Bruce elaborately tells how this creates new understanding, and makes new purposes possible to him. Both the therapist and Bruce give and receive in a generous matter, a burdened heart can be consoled, and understanding can emerge as an event of play, in Gadamer's wording. Bernhard argued that talking was of less importance to him. This doesn't have to imply that Bernhard appreciates conversation at a lesser degree than the others. He simply refers to spoken interaction as less important to him, without giving any reason. As stated elsewhere, communication is far more than talking, in both Gadamer's and Goffman's view.

When a patient visits a physiotherapy clinic, or the therapist visits the bedridden patient, a social encounter takes place, starting with the arrival and ending with the therapist's departure. During this encounter, both parties seek to learn something about the other, as a means to define the situation – a reciprocal information exchange (Goffman 1959;Goffman 1963a;Goffman 1964;Goffman 1967). Information is conveyed by many 'carriers': attire, demeanour, talk, movement, props, involuntary expressive behaviour or several others, overt, covert and imaginary. These signs are interpreted in light of earlier experience of that person or similar persons (e.g. other physiotherapists or patients), and in light of stereotypes (e.g. stigma, disability, prestige hierarchies or gender-dependent conduct). However, according to Goffman, we will not know for sure if this is the real or true "truth" about the other, as falsifying information is part of the deal so to speak. Either intentionally or not we are expressing ourselves, attempting to make a particular impression on the other in order to demonstrate our alignment in the situation. We deliberately *give* signs which are controllable

(e.g. speech, clothing, posture, demeanour), but we also *give off* signs (e.g. age-grade, gender, ethnicity, disability props) which are less controllable. These signs, which Goffman calls small behaviours, take on a moral character; we tend to interpret signs we receive from others as claims and promises, hoping not to be lead astray (Goffman 1959:14, 242). Gadamer and Goffman both stresses that “truth” is not the primary goal of interaction or conversation, but understanding – including openness on disagreement. Words, concepts, utterances and non-linguistic signs feed and move the conversation. Bernhard’s communication with his therapist (apart from the episodes with the headphones) may be embodied and in no need of words. His interpretation of her small behaviours may have reduced his claims on her verbal attention.

Later on the B-gentlemen give in to laughter when they recognise a common tendency to complain and unburden their hearts to their wives or fellow peers, but not to their doctor or therapists, even though the therapeutic encounter holds promising potentials. With their therapist or doctor, they admit to embellish their health status. Everybody laughs when this is discussed, recognising a well-known strategy, playing upon stereotypical representations of femininity and masculinity. Asgeir translates this to the Tarzan-like image, which represents iconic heroic masculinity; of being in control all the time, fit as a fiddle, and attractive to women. Bruce’s story reminds us that when this Tarzan game is of little relevance, you trust your therapist, the therapy is conceived of as a “talking situation” – an opportunity to unburden your heart, and air all kinds of worries. Charlie’s strategies as presented above follow the same line of thought and behaviour.

Common denominator – common ground

In the section above Bruce explained why sharing interests in common with his therapist is so vital to him, and later in the conversation he adds that having a male therapist makes for a particular type of relationship – between two men. Sharing common interests like sports fishing, the two men easily agree upon a situational definition, establish a *modus vivendi* and move beyond. A steady relationship makes it is easy to broach the bodily and personal concerns at each appointment. A more personal relationship between two men, developed over years, adds to the therapeutic effect, according to Bruce, and a personal benefit beyond the scope of the bodily concerns. An appreciated homosocial relationship creates another

scene for interaction. A common ground on which a true dialogue may emerge is vital to our health and wellbeing; it is where the art of healing medicine sits, Gadamer argues (1996). It means that the conversation between therapist and patient has the potential to support the efforts taken by patient and therapist to improve health. Or conversely, without dialogical interaction healing may be impoverished.

The D-ladies did not agree with Bruce, or each other, regarding same-sex relationship to their therapist. However, they did agree upon the impact of gender.

Daniela – I've seen women [female therapists] that had given birth, and women [female therapists] that had not, and it is a big difference, I think, but you can't get a therapist just like yourself (*group laughter*) maybe I've been lucky, I've seen women and men, but when I came to a woman, two in fact, that had given birth it became different, I felt it

Doris – I feel I've been better understood by men

Daisy – so do I

Daniela – maybe that's because of our disorders, even though we are not going to speak about that

Doris – I was thinking the same, I have a kind of disorder that men usually contract, but that's not all there is to it

Daisy – it's both

This is an extract from a discussion concerning the sex of the physiotherapist. The women have contradicting experiences, and standpoints. The youngest women (Daisy and Doris) have experienced problems with female therapists, including disrespectful treatment, lack of support and trust, and a nagging feeling that the therapist doesn't entirely believe there is anything wrong with them. Both had expected something else of a woman – they had expected understanding and comfort, and respect. These needs are met by their male therapists. The other women in the group (Daphne, Daniela and Diana) are happy with both their male and female physiotherapists, but still prefer female therapists because they feel that women understand what it is to be a woman, a mother or a wife, or a female employee. They also understand about the more intimate aspects of life – menstruation, fertility, pregnancy, giving birth and sexuality – and running a home. The importance of age and gender is acknowledged by all; the more similar the age, the easier the small talk. Daniela tried to explain that she appreciates both male and female therapists, but nevertheless had experienced a difference that made a difference – especially related to the female therapist's experience of pregnancy and giving birth. It's a pity, as she says – that you cannot have a therapist who is just like yourself.

Goffman contends that small behaviours take on a moral character; we tend to interpret signs we receive from others as claims and promises (Goffman 1959:14, 242). The signs we give off, as age-grade and gender, also takes on a moral character. Age and gender are social institutions which enable and constrain individuals, and make moral claims in a Goffmanian wording (Martin 2003:1256-8; Martin 2004). Martin, drawing on Giddens' affirmation of bodies that exist and consequently do things, instates the body and embodiment in institutional dynamics. People are situated actors who actively constitute and reconstitute social institutions (Giddens 1984; Martin 2004:1255-6). Social institutions, as age-grade and gender, are characterised by particular expectations, rules, norms and procedures. As Ridgeway & Correll states, motherhood is a particular social status, which in their study of the working life has a disadvantaging effect (Ridgeway & Correll 2004). However, their argument can be inverted. Motherhood is a social status which has a particular advantage to patients like Daniela. Contrasting the findings of Ridgeway & Correll, mothering biological children is a particularly valuable source of knowledge when encountering patients like Daniela. Her trust in the therapist's ability and willingness to understand her concerns and doings are multiplied when she learns that the female therapist has given birth.

The laughter in the last extract alludes to the subtext – the best match is a therapist who understands your problems, who is knowledgeable about body function and structure, activities related to task or actions, social participation and environmental factors. However, laughing may be ridiculing such a standpoint. The D-ladies explicitly articulated how they appreciated to be seen as gendered beings; fulfilling the expected performance of a woman within a heterosexual frame of reference (the group discussion may have constrained same-sex preferences). Age-grade is a social institution, as is heterosexuality, and the youngest women probably experience acknowledgment of their gendered being as attractive because their therapists are male, and the age differences are less than a generation. The slightly older women (40ish+) might not receive this kind of gender confirmation from a younger male therapist, because their age-grade makes gender a negotiable dimension in the relationship, as does their disability. When in pain or constrained by a disability, your sex category becomes one of many signs the therapist needs to negotiate and interpret. If gender is a social institution as Martin contends (Martin 2004), and the arrangement between men and women

are asymmetrical (Goffman 1979), cross-sex or same-sex relations are likely to be constituted differently.

The female athletes (C-group) tell us that they never run out of things to talk about with their therapists. Sport provides numerous issues to discuss, and they easily fall into conversation with their therapist. According to Carmen, talkative patients and talkative therapists are more likely to alleviate tension, create a sense of being acquainted, and build look-alike friendship as a common ground for therapy. Sports and athletic activities are competitive and playful. Introducing elements of both play and competition in therapy makes therapy similar to a sporting event, in Carmen's view. Cindy argues that she could not care less about the therapist's self-centred talk, but nevertheless appreciates a playful atmosphere. Carolyn and Cassandra added that young female athletes interact with their male therapist in a particularly playful, teasing manner, a heterosocial interaction which is both expected as a mark of the trade and an appreciated style. On the one hand, teasing and flirting are appreciated by the female athletes, but also seen as a non-professional demeanour. The innuendoes from their male therapist are verbal and non-verbal small signs; a wink, a smile, a comment, nothing like tampering. The male athletes do not appreciate any type of sexualised banter or teasing from their male therapists under the framework of their homosocial relationship. To Goffman, this is an exemplarily micro sociological situation where the presentation of self, staging a scene, playing the parts and believing the roles are put into play. As Conrad said, you have to believe in it, or at least convince yourself to believe in it. Believing is seeing. In other words – creating common ground means to stick to a particular choreography and make-believe or pretend that the (hetero- or homosexual) aspect is non-existent. At least this is what these young male athletes convey.

The A-ladies, aged between 60 and 75, believe their therapists' alienation from interaction and lack of interest in them is due to their age. Too often therapists keep running to and fro. Annabel thinks her age is a conversation killer in itself, and that it is easier to find mutual interests with people the same age. Age-grade is a social institution and fundamental category in social stratification (Grusky 1994; Martin 2004), and has a constraining impact on interaction in Annabel's experience. On the other hand, she argues, one can always make an effort to find mutual interests; we talk, and *then* we discover what interests us. But if patient

and therapist don't talk much, and there are little interest or curiosity about each other, obviously common interests will remain unacknowledged. Everything that can be understood is language, Gadamer argues. Then there has to be a dialectic movement in words or non-linguistic signs if a common ground shall emerge through dialogue.

Once in a lifetime – or rest of your lifetime?

When the importance of conversation is discussed, Desmond identified an important distinction between short and long-lasting relationships to a therapist:

Desmond – hm, but I think, there's a difference between the short and the long lasting relations, I think, the first times they might, and then, they have handled your body before, then it is going by itself, so there has to be a difference I think, because the short ones, they are different (...) people like us, we have been injured, been hospitalised, in and out, we have seen lots and lots of people, we know how to relate to it, but if you suddenly get an attack of low back pain, the doc looks at his desk, handing you a referral to a therapist, and off you go, and the therapist tells you to undress, then there is much tension there, we are receiving therapy due to a persistent problem, and know the outcome in advance whether this or that, but another one, a temporal, maybe he has a problem that could be sorted out – expectations, safeguarding, and then restored. But there is some matter that has made me wonder, and which could have been the topic for a thesis itself, is how the conversation, you lie there for an hour and have to talk about something, it's obvious that that conversation is different when it is two men or when it is two women

The first issue Desmond lights on is the benefits of seeing a therapist that knows your body. Having a therapist who is familiar with your body and its concerns is not as demanding as seeing a therapist (or doctor) for the first time. The “veteran's” expectations are probably different too, since their body knowledge and body politics have been crafted over the years. As experienced treatment receivers, they know what there is to know about outcomes and pitfalls. Desmond believes that new-comers have fewer pointers to guide them – making them more vulnerable. The second issue he details is impact of gender on the dialogue. While Desmond is talking, several co-participants express their agreement in the background. When he argues that you cannot just lie still and silent for an hour and that the small talk differs in same-sex and cross-sex relationships, laughter break out. The group have experienced and heard of therapeutic situations where patients are “muted” or deeply engaged in small or serious talk, and are knowledgeable of the impact of gender. This laughter could also be interpreted as making fun of the sessions they have experienced, where the dialogue was given poor conditions. Billig argues that laughter might be interpreted as embarrassment,

drawing on Goffman's studies of interaction rituals (Billig 2005:200-35;Goffman 1967). This argument will be picked up in chapter eleven.

Desmond – I believe you use, at least in a one-to-one-relation, you use some time to sound each other out, right, and then sit them somewhere, and if it's a man or a woman, same age, unmarried, then you do your personal ad test

Lots of laughter

Desmond – back and forth, right, and then you start to eliminate, and when it's eliminated out or in, you know it has an impact on the further interaction, something happens to you (...) and then you feel one's way, and you may create a fundament for further working, can this possibly become a working relation, or can it not

Donald – you notice, joke or fact, you notice the boundaries when you are conversing the therapist

Desmond – of course, (...) these people are used to people, they are clever at dealing with ephemeral situations, and they are up to date on all the news, because if they don't have anything to talk about they still have something, because they talked to the person before they saw you, so they are good at this

Donald – you notice, when there is one you have a good dialogue with, then he starts to laugh when he sees you, there you are! You notice their reluctance or opposition at once; you notice, at once

Duncan – you receive a lot when they know this, someone told me a prudent saying, if you have lost your whereabouts with your neighbourhoods, go see the physiotherapist or the hairdresser

Desmond introduced us to a test of his own devising, a 'personal ad test', to be used every time one meets with a new professional. The labels used elicit lots of laughter, as does the test procedure. Desmond, Donald and Duncan discuss some of the considerations invoked when deciding on whether a relationship is likely to last. By the means of dialogical interaction and conversation, one observes and measures up the other as a potential partner – in many ways. Goffman's concept of a working consensus is re-coined as a working relationship by Desmond. Being greeted with laughter, as in Donald's account, is interpreted as a welcoming of an appreciated friend. Smile or laughter is social recognition in Goffman's word; a process of openly welcoming and accepting an invitation to a mutual engagement (Goffman 1963a:113). Laughter and ridicule are social glue, according to Billig (2005) – avoiding embarrassing situations and smoothing social life.

Regular appointments – close encounters

Like the female athletes, male athletes discuss sports-related issues with their therapists, though frequent visits tend to pass beyond neutral and impersonal issues, to more personal concerns.

Clyde – it's often sports related topics, when you have a steady therapist, and he is part of the social environment, then it's mostly sports issues

Tobba – as training, teams, matches and so forth?

? – yes

Tobba – is this the same for everyone?

Charlie – every time I attend him, he ask about school progress, if it's ok, which topics are you absorbed by now, I've been there quite a lot, so he has started to pose these kinds of questions

Tobba – finished the football topic?

Charlie – yes, and then he asks, it's ok with me

Tobba – when you've been there frequently

Asgeir – do you talk about hobbies?

Carl – my therapist is a singer, and I used to sing in a choir, so there is a connection

Charlie – last time I attended mine, he started to talk about getting injured, the enormous pressure in the middle of the season, and talked about such things, he wondered, beating around the bush in some way, which was peculiar

The therapists favoured by these athletes are as old as or older than their fathers. The therapists might utilize this “senior” position to ask the athletes about their life outside the sports arena, e.g. work at school or pressure on the players to stay fit during the season. These relationships relate to Parsons' student-teacher relations, where fiduciary responsibility is enacted (Parsons 1975). As identified above, age-grade is both enabling and constraining interaction, and intersects with gender. Daisy, like Charlie, has this dual attitude to remarks by her therapists:

Daisy – I have to say, I'm returning to him I always return to (*laughter*), he is in fact a genius when you're on the bench, because he starts off by talking about the latest newspaper or the latest news on the radio, he's doing all the talking, I'm just lying there, listening, right? I don't have to make any efforts, and it's a really safe territory, because he's not touching upon the real matters of life, but if he touches on my disorder, puts inklings towards this and that, have you thought about this or the other, but still, it's safe. But a few years ago, I attended some female therapist, she didn't take me seriously because I was too young (...) then I thought, no, this I can't take, on the top of the rest, that would have been my reaction, because I can take a lot more toughness from a man, but not from a woman, I'd expected her to understand much more, simply like that, so my expectations were huge

Daniela – but it's not just about listening, my day to day condition is very variable, some days I manage this, and other days I can't, and then it's important to me to that this is recognised and understood, and we can discuss, today you can just forget that, and then you have these therapists that keep on: 'you won't improve on less you do this or that', but if you had your afflictions for a while, as I have, then I am the one who knows me best, and then, if someone in a condescending manner is telling that he knows my body, then

Diana – but you did it yesterday (mimicking voice)

Laughter

If the environment is safe, i.e. you trust your therapist and enjoy the relationship, you can accept small talk about problems associated with your disorder, your career, or your life. Charlie, being younger than Daisy, finds these comments peculiar, whereas Daisy is accustomed to this kind of chatter. Above Daisy's varying experience of male and female therapists were explained. Earlier on she had told us about the therapist she had had for at least a decade, and how and why she has taken breaks from him – both to spice up her life, and as a necessary antidote to mutual boredom. The laughter alludes to a burden many patients recognize – trying to find a therapist that meets your needs. Daisy reaffirms her preferences when she changes therapists now and then. If you have few experiences, then you won't know if your warrants are legitimate. Daisy also alludes in her story to her need for a sympathetic ear. The therapists have to exercise their ears' sensitivity, in Gadamer's terms. Her current therapist seldom gets beyond small talk, and avoids risky topics like her disorder and expectancies of life. However, there are inquiries from time to time, which she accepts, because this therapist shows that he recognises her problems and the challenges she faces. And more important, he acknowledges her agency and priorities; her body politics.

Daniela's story is about a patronizing male therapist. Diana's mimicking comments on his "know-all" attitude makes everybody laugh. They ridicule therapists with an omnipotent ego, while affirming the group's shared experiences, recounted in so many words and so many ways during the sessions. The laughter affirms a familiar experience – when one's day to day condition bounces up and down like a roller coaster, but your appearance stays almost the same, and your professional provider does not listen to your words or appreciate your own bodily knowledge. Everybody seems to know the feeling of making an impression they had not intended, and recognise the difficulty of re-negotiating such a 'slip of the body'.

Your looks gives promises on your behalf, they give off signs which may carry unintended connotations. Some of these signs have fallen out of step with the body, and any attempt to convey a different impression by speaking is difficult. The signs given and given off take on a moral character, as Goffman argued (1959:242). We tend to treat other present on the basis of the impression they give now about the past and the future. Communicative acts are translated into moral ones. The observer employs a multitude of standards pertaining to politeness and decorum, pertaining to social interaction and task-performance, Goffman

argued. Henceforth daily life is enmeshed in moral lines of discrimination (ibid.:243). When Daniela performs her body politics, she relates to the standards that she knows she is judged by, and she carefully constructs some disruptions where she can engender her alternative performance. This is a basic dialectic, according to Goffman. Dialectic is synonymous with hermeneutics and conversation, Gadamer argues. As such, Daniela demonstrated to us that hermeneutics is a way of understanding and enacting the rounds of daily living.

Daisy's account of what she expects from a female therapist, and Daniela's story about a patronizing male therapist, touch upon the moral character of expressive signs. If the interactants fails to behave as anticipated, e.g. the female therapist fails to meet stereotypical feminine ideals, or the patient's appearance conflicts with the body's condition, Daisy and Diana are likely to feel betrayed, embarrassed and angry. And the therapists may feel the same way. Situations like these are familiar to many of the participants in this study – and many of them work hard to avoid being seen as a sissy or hypochondriac.

Treatment and dialogue

The dialogue between the doctor (physiotherapist) and patient belongs to the process of treatment, and remains important throughout the entire process of making a recovery. It constitutes the area of common ground from beginning to end (Gadamer 1996:127-8). All the different forms of language use can be seen as various modifications of the more basic form of dialogue, the interplay of questions and answers. Recall Gadamer's notion of dialogue in *Truth and Method* (Gadamer 2006d)

To conduct a dialog requires first of all that the partners do not talk at cross purposes. Hence it is necessarily has the structure of question and answer. (...) For as we have seen that to question means to lay open, to place in the open. As against the fixity of opinions, questions make the object and all its possibilities fluid. (TM 2006:360-1)

The experiences of the participants lend support to Gadamer's notion of the therapeutic conversation; it is not mere talk, it is an essential aspect of therapy and of healing, and vice versa. If the dialogue is constrained or interrupted, or people talk at cross purposes, therapy might end up doing next to nothing. Goffman summaries this as alienation from interaction: When an encounter fail to capture the attention of the participants, but does not release them from the obligation of involving themselves in it, then the persons present are likely to feel

uneasy; for them the interaction fails to come off (Goffman 1967:135). As Goffman notes, social encounters differ a great deal in the importance that participants give to them. However, when an incident occurs, and spontaneous involvement is threatened, then the situation at large is threatened. Unless this is attended to, the minute social system of a therapeutic encounter will be disorganised, and the participants will feel unruled, unreal and anomic (ibid.).

Closing remarks

Physiotherapy always includes talk and interaction in one way or another. Medical history is taken, present concerns are aired, and diverse assessments are carried through. Following this, dedicating a chapter to dialogue might seem like doubling up. However, as the participants have empathically conveyed; talk is not talk. Talking *may* be dialogical, but not by default. Talking is intimately connected to thinking, and some argue that thinking is an inner dialogue. In *Arguing and thinking* Billig celebrates the argumentative spirit (Billig 1996). Mere talk, as polite consensus or silence, is no food for thought. Arguments and disagreement is praised as the root of thought. A spirit of contradiction is sought. According to the participants in this study, to purport bodily changes and well-being dialogical conversation is of utmost importance. A common ground is a necessary prerequisite for therapy. This ground is created though dialogical interaction, an interchange of arguments, that purport and denotes movement and change. However, it is the degree to which one is caught up in the subject matter that measures the value of the dialogue (Ross 2006:112). The primordial prerequisite is the physical presences of the therapist, and subsequent an attentive awareness.

The next chapter deals with the bodily interaction in physiotherapy; aiming at making bodily interaction problematic, not doubling up.

6 Bodily interaction – The dialogue of touch

When a set of individuals have joined together to maintain a state of talk, non-linguistic events can most easily function as moves in a conversation (Gadamer & Grondin 2006:93-5; Goffman 1981:71). The body is a particularly relevant sign carrier in physiotherapy – it is literally a non-linguistic mover in conversation. Both interactants read and interpret signs which are available to all present. The therapist, however, have access to additional abundances of sign from the patient's body, by way of touch and manual handling.

Social interaction as face-to-face interaction or body-to-body interaction, consist of innumerable small behaviours, signs, gestures and sounds, which both precede and accompany conventional behaviour (shaking hands, walking) and linguistic conversation (words, utterances). These small behaviours and gestures have an impact on bodily interaction, as this chapter will demonstrate. To the participants in this study, the hub of bodily interaction is touch; to be or not be touched, and the perceived quality of touch.

Any internet search for 'touch' retrieves huge amounts of entries – embracing baby massage, sensual massage, therapeutic massage, health promotion, palliative care, torture, self-mutilation, poems, songs, pulp fiction, prose and factual prose, films and so forth. In the realm of factual prose and scholarly literature, nursing is predominant, followed by psychotherapy and touch therapy. Physiotherapy is sparsely represented. Interestingly though, in the realm of evidence based medicine several papers are published by Weze et al. that endorses the significant healing powers of gentle touch (Weze et al. 2004; Weze et al. 2005; Weze et al. 2007; Weze, Leathard, & Stevens 2004).

I have been touched by the multiple ways participants had of elaborating the importance of touch, and Ole Fyrand's *Berøring (Touch)* moved me further (Fyrand 2002). Fyrand draws on personal experience of everyday life, and professional experience gained through his everyday occupation as a dermatologist and professor in medicine. He also draws on a huge body of prose, fiction, art and philosophers. However, his fascination with the skin transcends traditional medical rationality, moving into the realm of metaphysics or enigma of the skin as a sensitive and sensual dimension of being human.

The group conversations created a locally situated web of touch from physiotherapy; illuminating how touching another's body at the same time touches you; literal touch and metaphorical touch – as through small behaviours, gestures and glances. Even so, touch conveys broad, but often vague messages, potentially complicating interaction and communication – not to mention its effect on the outcome of therapy. Touch is a fundamental mover in conversation. In *The renewal of generosity*, Frank shares with us a warning he received from a technician who came to draw his blood. “Remember” she said to him, “everyone that touches you affects your healing” (Frank, 2004:27) These words made him understand that his task was not to get through cancer treatment as such, but to reassemble a life that had been touched in so many ways, often by people who seemed indifferent to his healing. The technician Frank refers to, however, drew him into a relationship of care – a relationship, a dialogue not only of words, but of touch. The way we touch each other affects who we are – and may become. Tiffany Field's *Touch* lends scientific support to Frank's experiences and reflections, rooted in her tradition of psychology (Field 2001). Her basic proposal is that people of all ages need a daily dose of touch in addition to diet and exercise – without it we might die. She has studied premature babies, children, adults and the elderly. Her arguments converge upon the fact that good touch, a touch that nobody withdraws from, helps people to flourish.

Touch is intimately connected to emotions. This study does not inquire into people's emotional selves or emotional experiences with physiotherapy. However, through this thesis, whenever I seek to make reflections on the issue at hand, I inevitably draw on own experience and understanding, along with what I have learned from the participants' and other's writings. As a clinical tutor and associate professor in physiotherapy, hands-on therapy and touch was a matter close to my heart. I was concerned about the increased emphasis on instruction, guidance and physical education, and worried about the fate of touch in physiotherapy. As Lupton states, every author have their (emotional) investment in their project and text (Lupton 1998). The subject matter of the present study is cognate to her line of “passionate sociology”, but does not pursue emotions explicitly. When the participants discuss touch, its relevance is easily imparted to me.

Setting the scene – bodily encounters

During group discussions, talking about physiotherapy equated talking about touch in one way or another. Touch-discussions related to longing or dreading to be touched, about painful and pleasurable touch, the touch of a woman or a man, the missing touch, and the communicative aspects of touch. As a social practice, touch and bodily interaction are literally a touchy subject. Except for the female and male athletes, all groups raised the matter repeatedly. Touch is a fluid concept, and were described as patting, stroking, caressing, fumbling, groping, intimate, tickling, palpating, titillating, irritating, hard, soft, superficial, pleasant, deep, painful, marvellous, female, male, clinical, torture, impersonal or likewise. Reference was often made to its conspicuous absence or to particular touchy incidents and experiences. While the women and men in the A and B groups lacked and longed for the therapeutic touch, the women in the D-group dreaded its pain producing aspects, and the men in the D-group both lacked and enjoyed touch. The young women and men in the C-groups are more concerned about the possible misunderstanding a touchy relationship to their therapist may elicit. First, a story about the pleasurable dangers and healing potential:

Beatrice – my therapist, he had learned some manipulative techniques, and I broke one of his ribs, he aimed at loosen my neck, it was marvellous, he was lying upon me, that was fair enough (*laughter*), and then my elbow slipped and hit him in his chest, he was holding me tight, it was a close encounter so to speak (*laughter*), and next time I turned up he said, you broke one of my ribs, and I said no, I didn't, you did it yourself (*laughter*) but my neck was loosened

It is almost paradoxical – they ask and long for close and palpable bodily interaction, but when one of the women gets the treatment she desires, the therapist hurts himself. The group makes a “cost-benefit analysis” of her treatment, and arrives at the conclusion that the result was worth the cost. Close encounters and bodily interaction are literally doing something to us. Beatrice told about how bones and tendons are either repaired or injured – or both.

In the following extract we agree upon the fact that physical touches move us on a personal level – and make a significant difference to therapy.

Tobba – you know, hair dressers, they touch people, I wonder, when you touch someone, when we touch each other, something's happening
Duncan – something happens, for sure
(...)

Donald – you notice their interest, if they only tell you to lie down, and they set to work, now I have finished, get dressed, or they show some interest and talk, then they do it in a way that is more comfortable than when it is just get it over with, and finish
Desmond – I see, here's ammunition to make up more than ten theses

Lots of laughter

Desmond teasingly points out for my benefit that *this* topic is enough ammunition for ten theses. There is more to touch than being touched. It is a communication on your body – whether by therapists, friends, acquaintances or strangers. Touching naked skin may convey appreciation, acknowledgement, distrust, disinterest, disgust or dismay – and intersects with age-grade, gender and the prestige hierarchies of diseases. David has embodied experiences of these intersections:

David – I thought about what Duncan said about touching people, I've experienced quite often a need to be touched, that's like a bodily pain, and I'm not kidding!

Asgeir – I think lot of people have had those experiences

David – and then there is something, its just the way it is, but which I find very hurting, that the women very often use gloves

Tobba – gloves??

(...)

Duncan – its impersonal, it's like being a parasite

(David in the background – yes, yes, yes)

David – yes, it is awful, I usually tell them they are treating me like contaminated waste

Lots of laughter

Being touched can be painful, but *not* being touched can be even more painful. It is like an emotionally embodied pain. Fyrand's book is devoted to this topic, as in this poetic construction: all kinds of touch seem like the growing wings of love (Fyrand 2002). When nobody acknowledges your body by touching it, and hence refuses to show any appreciation of you as a person, the stakes are high. And furthermore, David's embodied pain is not recognized or dealt with in the same way as physical pain – e.g. a painful injury, broken bones, angina or myalgia. Besides, if the pain is the pain of bereavement, being treated by somebody wearing plastic gloves is doubling up pain. A central issue in David's story is sadness. The metaphor of contaminated waste in his self-deprecating joke is one way of passing on vital information about his life, and of requesting support from a group of peers. Self-deprecation often alludes to status-hierarchies, acknowledging ones positions below the others present (Hay 2000; Hay 2001). As such, self deprecation might serve to evoke prestige

rankings of people with disabilities, where a congenital deficit is ranked below spinal cord injuries.²⁶

Lacking and longing

Four of the participants in the female B-group pinpoint the main issues of being touched.

Bonnie – there is something that I appreciate, that’s when they use firm grips, so you can feel it, as if they use themselves, that’s the best, I do not care for bits of superficial touch

Britney – I want them to pinch and squeeze, not just fumble, that’s my way of expressing it, I want them to use some force, dig into it (...) and tell I her what to do, then she does it, but next time she won’t do it, then I must tell her again, but anyhow, it is nothing like the treatment we get in the Mediterranean, that was marvellous, but it’s a long and expensive trip, there should have been some more around here

Barbara – I agree with the others, more than often I get the feeling of being patted on the neck, not anything more, that’s not good for anything, but I’d like to tell you, if I dare to tell were I’ve been, I’ve been to Clinic, and he is very clever at massage

mFB?²⁷ – yes, that is something quite different, I can’t believe they are doing the same thing, I’ve been to two women and one man, the difference is huge, and I tell the women I can’t feel you touch me, please do it rougher, and they say they are getting at it until exhaustion, I don’t understand it, no I don’t

In summary, the B-ladies are of the same opinion as the B-gentlemen. They all appreciate firm and hard-working hands, and are convinced that avoiding painful parts of the body impede improvement. A common refrain is that you need to fight fire with fire. They all long for pleasurable bodily experiences, a retreat from the strains of daily living and professional caress as much as thorough treatment. It is a legitimate time out from everyday life to immerse in wellbeing (Parsons 1975), a Continental tradition still available at convalescence resorts in the Mediterranean countries. The experiences of the woman and men in the B-groups apparently contradicts the findings of Weze et al (Weze, Leathard, Grange, Tiplady, & Stevens 2004; Weze, Leathard, Grange, Tiplady, & Stevens 2005; Weze, Leathard, Grange, Tiplady, & Stevens 2007; Weze, Leathard, & Stevens 2004). Weze and collaborators have studied healing by gentle touch; an alternative and complementary medicine. Their findings give evidence for the benefits of applying touch therapy. The participants in my study did not

²⁶ Personal comment and personal observation, and a common backdrop in the realm of disability. Spinal cord injury is a predominantly “risk taking young man” condition, and rehabilitation and living nurtures upon heroic masculinity.

²⁷ Unidentified member of the female B-group.

give any records of experiences with alternative touch therapy. Nonetheless, their preferences for firm hands-on treatment can not be interpreted as a rejection of alternative touch therapy. Further more, they tell me they are not unwilling to exercise in a gym or suchlike. On the contrary, they want the therapist to encourage them to take responsibility for own their health, and to teach them how to monitor progress and maintain motivation. But additional hands-on therapy is requested.

A wo/man's touch

The above list of touch-related adjectives included male and female as descriptive categories. Annie compares and contrasts treatment she has received from male and female therapists working in different cities. According to her experience, male therapists use their hands to detect painful points, and successfully alleviate her problems. By contrast, female therapists apply heat packs and disappear, and when they eventually turn up again, they apply some machinery. Annie has tried to communicate her preferences, but unsuccessfully. Annabel calls attention to the fact that effect of therapy might be delayed, even though it seems as a waste of time at the time. After a while, she says the results can be miraculous, though in her case it was not much help in the beginning. Bridget tells a story about a particular female therapist who was very firm in her approach to treatment, even firmer than her male colleagues. Recalling several group discussions, I contrast this experience with what others have said, prompting Bridget to answer that the one who complains has not seen the same female therapist as her. Then everyone in the group laughs. All groups agree that male therapists have a firmer touch, and Bridget was the only one to deny it. Later on, Bridget comments on her own statement and adds that she probably was in a very sensitive condition at the time. Depending on your affliction or pain, even a gentle touch can be painful – whoever the therapist is.

The discussion about this commonly observed difference between male and female therapists evolves into a discussion about hands-on therapy in several groups. To Alexandra, female therapists do not have sufficient strength in their hands and arms to do the work properly. Alan says that physiotherapy is a physically demanding occupation, if it's to be done properly. In much the same way as female welders or bricklayers get physically worn out, the same goes for female therapists, Alan adds. Annabel suggests that the reason therapists use

mechanical equipment is that they are dealing with several patients at the same time. The groups mention on several occasions therapists who never stay put, answering phone calls, among other duties. The laconic comment by Annabel that introduced the chapter on dialogue summarizes the general feeling. It is impossible to stand by the bench and work. One of the exchanges between the A-ladies included a story about a Danish physiotherapist based in the Mediterranean region who worked hard with her hands all day, allegedly because the therapy room where poorly equipped. The Danish therapist admitted that she used machinery when working in Denmark. What hands-on therapy actually requires of the therapist remained unanswered.

The young men of C-group and the men of D-group had recourse to biological instinct to explain interaction between the sexes – and why male and female touch is so easy to tell apart.

Tobba – (...) it was girls, and they did not pick the black bra or the silk lingerie before seeing a therapist, because if they did, what would the (male) therapist think of them...

Charlie – I can understand that (...) it's the male instincts that get started, right, and he thinks – I must not attend to this, not think about this – but it is still there

This illustrates how ready made interpretive schemes of biological sex as a dominant sign vehicle and hence an uncontrollable dimension of gendered interaction, are evoked in our discussion. Our comments allude to socially shared knowledge, or folk models, on gendered interaction. We do not know for sure how, or if, lingerie and male instinct are put to play in the imagined encounter. The men of D-group discussed the impact of the therapist's gender in a light-hearted manner, as did the C-gentlemen.

Duncan – I read this, and I thought, is it really a good idea to stir up this male/female stuff, I didn't have any consciousness about it, but when the issue was raised, I started to think (...) I've seen women and men (...) did it make any difference to how I related to the therapists, and I arrived at David's standpoint, two women get befriended, it's more easy as a therapist or a patient, and I feel it's the same when I attend a physiotherapist, when it's a man, it's natural to throw the clothes away, get onto the bench and receive treatment, and when it is a woman, I do not let go of my tyres in the same manner

Lots of laughter

Duncan – something happens to you, I have to admit it
(...)

Duncan – and I thought, damn it, maybe it's a difference between being treated by a woman or a man

David – from my point of view, whether it's a nurse or a female physiotherapist, then I can feel the touch in a different manner when I'm touched by a woman than if I'm touched by a man

Tobba – how do you explain that?

David – hm, hm

Duncan – instincts at work

Laughter

David - yes

In this extract, Duncan is seen venting his thoughts about having brought up the subject of male/female physiotherapy. However, he confesses, the information leaflet made him think over physiotherapy he had undergone. His conclusion was the same as David's; it is more relaxing and easier to undress in front of a man than a woman. The men in the ABD-groups acknowledge the impact of gender on touch, and, except for the young C-men, they all confess to find pleasure in a woman's touch in most situations. Their laughter speaks of a common experience of titillating cross-sex relations within a heterosexual framework – and of potential embarrassment and social disruption of the situation. The sex-neutral and asexual glossing is easily removed. As heterosexual males, their gender identity and the social gender order are confirmed by female therapists massaging male bodies, providing a pleasurable bodily experience.

Clinical touch

The extract shows David introducing the concept of 'clinical touch' – intended as a derogatory term, designating an impersonal or mechanical manner of palpable handling of someone's body. This concept makes it possible to categorize touch by its relational and communicative effect, as opposed to descriptors like hard/soft or male/female.

David – about that matter of gender, I can feel it very strongly in relation to the home nursing staff, because if they can't relate to me in a clinical manner and do a job, like mending a car at a garage, then it's OK (to them), but if I'm having a blue day, then they are not willing to deal with me at all

Asgeir – what about a blue day?

David – if I'm depressed, then they do not want to have anything to do with me

Tobba – you feel they close off

David – yes, yes, yes, and that's the gender matter, 'cause I'm a young man

Tobba – home nursing, that's only women, and then you're a man, not a body they can get at

David – yes, yes, first of all that's terribly hurting, and second, it's very serious that the nurses act in that manner, 'cause I talk to a lot of people in similar situations as my own, and all tell off the same

Tobba – they have similar experiences?

David – hm, yes

Tobba – but listen, I think, if there's any girls your age with your disorder, does the same happen to them?

David – no

Tobba – are they more like friends?

David – I think so, I couldn't know for sure, but I think so

By touching another body, whether as a professional, a friend or a lover or a stranger, one establishes a relationship. This relational touch comes in addition to the physical pressure from handling the skin, muscles, bones or tendons, whether it is applied as a loving touch, physiotherapeutic or nursing touch. David speaks frankly about the vulnerable situations where you are handed over to an unknown professional or chance acquaintance. Touch is a sign vehicle in communication and interaction. As other signs, touch are perceived and interpreted as a promise and an obligation. Touch takes on a moral significance. In the excerpt above, the role of touch as moral agency is ignored (Field 2001;Fyrand 2002;Goffman 1967;Holler 2002). Goffman remain us of the vulnerability of the interaction order, which David relates to (Goffman 1983:13). Recall Field's proposal is that people of all ages need a daily dose of touch (Field 2001). David told us about painful longing, of having a hunger for touch that resulted in physical pain. Fields psychological studies give lots of evidence for the importance of close relationships with others.

Having a disabling condition inevitably leads to several health-related social encounters where your bashfulness is challenged. Donald relates gender to nudity, and compares this to his memories of embarrassment when he was newly injured. Desmond adds that you get used to it, and all the men in the group laugh a lot. Three of the four acquired their disability after the age of sixteen, and hence have some experience in common of intimacy, nudity, strangers and bashfulness, underlined by laughter. The fourth participant has a congenital disorder, but still shares these experiences. In the initial phase after an acute injury you need help for all kinds of personal needs, and a lot of help to move around. This is a hard learning phase, but you do learn. After a while, nudity, bashfulness and embarrassment become context-bound and habitual – and carers are objectified. Changing into swimwear on a beach is not comparable to attending an appointment with an urologist – at least not when it comes to bashfulness. The hospital setting, in particular an urological examination, often requires access to your genitals. On a beach they are supposed to be hidden. The thought of refusing a urological examination of the genitals is laughable. It's embarrassing to attend, but even more

embarrassing to refuse when needed. Parsons reminds us that acceptance is agency – it is not submission or passivity, it is to share and participate in taking fiduciary responsibility for ones' own health (1975:267).

Manoeuvring in treacherous waters

The slippery road from pleasurable massage to wanted or unwanted sexual attention is at the core of the conversations discussed below. I have mooted the idea that undressing and hands-on therapy might cause misunderstandings, or be exploited. Beatrice supports the idea, and shares her own experience of pleasurable therapy and massage.

Beatrice – you're getting a particular form of closeness when they're working on your body, it's pleasurable, but they're doing it very different, and sometimes you can feel a particular pleasance, and I reckon that could be misunderstood by some, I wouldn't dismiss that possibility

The intersection of age and sexual attention is highlighted by two different cases. The first concerns several young, pretty bosomy women and men past their prime, the second women well on in years and young men. Britney suggested I could ask the adult men how they feel about being “kneaded” by a young, beautiful woman. She imagined they would take the utmost pleasure in a treatment session. This elicits a burst of laughter among the women in the B-group, and a laconic comment from one of the others. The men, she said, would never dare to admit they enjoyed the “kneading.” The subject then turns to a situation where a female therapist has to deal with unwanted overtures. One of the therapist's male patients took advantage of the situation.

Beatrice – and then we've these men, in their prime, wanting the female therapist to touch their body on other places than recommended on the referral

Tobba – what are they doing then?

Beatrice – the one who told me, she is quite determined, and told him that his desires was not a part of physiotherapy, and advised him to see a massage studio

Tobba – they could deal with it

Beatrice – yes, he became nasty, she did not want to see him again

Tobba – did he disappear?

Beatrice – oh yeah, he didn't have any pains, I said

Beatrice tells us another story, where a male therapist risked both his reputation and his clinic, when a female patient made several persistent passes at him, and threatened to file a complaint of sexual abuse unless he accepted her “invitations.” While Beatrice tells this story, there are many comments in the background. A few of them are decipherable, and back

up Beatrice's story; it is not inconceivable that patients are out of line. Both extracts call attention to the volatile relationship between patient and therapist, and the dangers associated with the pleasurable touch. The male patient imposes his wishes on a female provider, and the story goes that she chooses to perform like an asexual professional instead of a sensual woman. By means of this performance, she is able to discharge him as a patient. In the second extract, the female patient is able to scare the male therapist by drawing on old stories, hearsay and stories reported by the media, probably scaring his family as well as the therapist. This particular therapist allegedly brought his wife to the clinic, and it is said that this ended the harassment. As a male therapist he was easily trapped by stereotypical images of men taking advantages of women, and particularly male physiotherapists abusing half nude women in cubicles.

With these stories in mind, Britney explains why she would have dreaded to have a young male therapist deal with her upper inner thigh problems.

Britney – few people are like that, but still, I would have dreaded seeing a young male with my thigh, he could think I was an 'old pig' (laughter), it's those situations, some are very intimate towards you, and you think, did I comply too much, did I make it happen, then it all turns back at you

? – very difficult

? – claim against claim

? – it's your own fault

? – look at the poor young girls, their dressing, it's just to slap their [abusive men] faces and tell them to stop, but they do not dare, so if they attend a therapist that loves to caress a bosomy young lady, they just turn red, maybe they think it's the way it is, even though unpleasant, they do not tell

? – but when you grow older, then it's easier to tell

Britney – but we're not so interesting to touch either

Lots of laughter

Tobba – so when you dare to object, you are not given the opportunity

? – well, there might be someone that took a fancy in us as well

All the women are concerned about the vulnerable situation young girls might find themselves in with the risk of being abused, and even held responsible because of the way they dress or other conduct. Filing complaints about a professional is also emotionally exhausting. However, they do take precautions even as grandmothers; women are ascribed responsibility for keeping sexuality at bay. Some parts of the body are saturated with sexual connotations, and treatment in these areas should not be left to chance encounters. When I give them my interpretation of the connections between age and sex, with increasing age

often accompanied by an increasing ability to stand up for oneself, Britney adds that we grow less attractive we grow older, implying; and we know it. The burst of laughter this occasion confirms the adage: youth and beauty before age and wisdom. Hence, by the time you have the competence and nerve to complain and police your boundaries; you are not given any opportunity. To this is added a laconic comment: what if someone likes the older body?

Touch and agency

As suggested above, we have few folk models or interpretive schemes at hand when it comes to being touched by another person. This leaves communication at risk as illustrated in this chapter. Linda Holler (2002) examines the role of the senses and the emotions, especially touch, in moral reflection and agency in *Erotic Morality. The role of Touch in Moral Agency*. She argues that we need to reclaim our sentient awareness, a necessity for our physical and moral wellbeing. As a psychologist and theologian, she advocates an ethics that is body-affirming rather than body-denying. She argues that just as dualistic disembodied philosophy inevitably gave rise to an ethic based on *logos*, so embodied awareness gives rise to an ethic based on *eros*. Whereas *logos* is based on rules, authorities and duties, *eros* is based on a somatic, intuitive form of agency in which empathy, compassion and care are central moral qualities. Holler uses touch as the primary sense around which she composes a discourse about moral agency. The erotic touch unites sensory and emotional feeling.

The ways that we are physically touched help to determine our repulsions, attractions, and indifferences and our ability to respond emotionally to what goes on around us, that is, to care passionately and compassionately about our own lives and the lives of others. Eros is this passion for life, the embodied expression of the relational nature of existence in constructions of identity, awareness, and action. (...) It is “creative energy empowered” because one is touched from within and from without, both emotionally and physically. (Holler 2002:1-2, quotation marks in original)

An erotic morality does not necessitate literal touch. Even so, touch amplifies our aesthetical sensitivity and sentient awareness, and makes the physiotherapist *bodily* responsible for the Other. Physiotherapy is touch – metaphorical, literal, relational, dialogical and emotional. It is to be touched from within and without simultaneously. Even though the therapeutic sessions may be ephemeral, patients make their judgements. Holler’s moral agencies are lost in professional encounters where therapists alienate themselves and their patients from interaction by placing themselves outside the responsive frame – leaving and arriving several

times during an appointment. However, the participants told us about outstanding examples of erotic morality, where the patients receive body-affirmative therapy – where the art of healing emerges. If the patient and therapist both feel passionate and compassionate about each other, a caring and empowering relationship is established, upon which the interaction may rest and succeed. The therapist's touch provides information about the therapist's skills, moral agency and compassion for us as fellow beings. The touch may feel less than skilful, it may convey a lack of interest, reluctance or loath, even feel instrumental.

Appropriating physiotherapy reveals touch as a gendered interface as well as an ethical agency. The power of touch may be understood as the power of dialogue – incarnating a three-dimensional conception of touch as a symbol, a practice and a subjective experience. Touch is vital, and touch is dangerous. Touch can be healing and empowering or oppressive and wounding within the environment of professional relations – as in physiotherapy. An aesthetic sensitivity and dialogical creativity are needed to create recuperative, healing physiotherapy. Recall Ross' argument that an event of understanding is an experience of tarrying, and her worries about a possible cultural loss of hermeneutic acuity (Ross 2006:105). The experiences of tarrying, engrossment, being played and aesthetic attention have a significant ring to Holler's arguments on the erotic morality of touch.

Closing remarks

Bodily communication is construed as a prerequisite for making an encounter between physiotherapists and patients come off. The physical proximity and hands-on therapy is constituted as a distinct form of communicative interaction, and hence for understanding and change. The participants imparted an understanding of touch on the one hand as care, support, encouragement, comfort or a means for well-being, and on the other hand as clinical, impersonal, hurting, painful or offending. Gender and age, as well as impairments and disability cut across the communicative divides, and may inhibit or facilitate the establishment of a working consensus. Disruption in the bodily dialogue, whereas due to the therapist running to or fro, or other issues, left the patient vulnerable. Not being touched may be painful. A bodily dialogue is precariously construed and takes time to establish. It may be impossible to mend or re-establish a new bodily dialogue or working consensus if it is broken during an encounter.

The next chapter turns to an issue of self-presentation: on being neat.

7. Self-presentation: On being neat

Bodily interaction is locally orchestrated at the therapy centres, and acquires meaning for the patients, as illustrated in the two previous chapters. This interaction is managed by means of verbal and bodily communication, but also by means of how patients relate to themselves and their bodies. The body is the material object of the interaction, but also the symbolic device for patients to implicitly agree (or disagree) on the definition of the situation (Sasatelli 1999:244). Further more, the body mediates agency, i.e. what people actually do to prepare themselves for physiotherapy.

The implicit rules of cleanliness, neatness and conditions for undressing are explored in this chapter. These issues serves to illuminate the passage from the outside world, to the inside world of physiotherapy. According to the views that emerged in all groups, neatness and cleanliness go without saying – they are a fundamental way of being – an embodied accomplishment. However, this allegedly taken for granted demeanour receives precarious considerations before a therapeutic encounter. The issues of cleanliness and neatness take on a moral character – to which we pay particular attention.

Every social system have implicit rules for cleanliness and dirt, as Mary Douglas eloquently demonstrated (Douglas 2002). Everybody knows on a bodily as well as cognitive level that clean appearance and neat attire are appreciated, and that the smell of bodily waste or decay is unaccepted. Additionally, our culture, as other cultures, has its own system of approved or disapproved dress codes and ornamentation – whether engraved in the flesh of the body, or carried as clothing or fragrance or expressed as demeanour. When the patient's body is the hub around which the therapist-patient relationship revolves in physiotherapy, it follows that the “neat and clean” scheme serves as an interpretive background for both. However, general consensus about the principles of neatness and cleanliness tells little about why or how each individual attend to their own body.

Discipline and cleanliness

The notion of neatness and cleanliness implies low tolerance of dirt and decay – or recognition of disorder. This goes for objects as well as for bodies. In her famous *Purity and Danger*, Mary Douglas says that if uncleanness is matter out of place, then we must approach it through order (Douglas 1994:39-41). Order is sustained by keeping the dirt and order separate. Dirt is the by-product of systematic ordering and classification of matter, and rejection of inappropriate elements. Douglas argues that culture, in the sense of the public, standardised values of a community, mediates the experiences of individuals. It provides in advance some basic categories, as a positive template on which ideas and values are tidily ordered, and above all, it has authority. The public character makes its categories more rigid. On the one hand, a private person may revise his assumptions as a private matter. Cultural categories, on the other hand, are not easily subjected to revision. Nevertheless, any cultural classification must give rise to anomalies and events which seem to defy its premises. We need dirt to sustain the idea of order (Douglas 1994.).

Isaksen's studies of the body as producer of dirt and waste elaborate the issue of being neat and clean (Isaksen & Dahle 2000;Isaksen 1994;Isaksen 1996;Isaksen 2001;Isaksen 2002). She has called her studies the sociology of loathing. Whatever the reasons, sometimes and somehow we might need help to take care of our bodily waste – whether it is sweat, saliva or faeces. If we are in a hospital or nursing home, this is relatively unproblematic. If patients and staff agree on the same definition of the situation it makes it possible to endure – both for the recipient of care and the giver of care. Within the confines of a home, on the other hand, it is more difficult to sustain a definition of a situation that allows daughters and sons to help their parents with their bodily waste or processes of decay. Loath may outweigh the desire to provide loving care. Isaksen draws on Norbert Elias and his study of the civilizing process, and on Douglas and Shilling, to illuminate her argument about a civilization process which induces social fears of embarrassment and shame (Elias 1982;Schilling 1993).

Paradigmatic work of Norbert Elias from 1939 (Elias 1982) has inspired several authors in the study of manners and cleanliness and discipline. Ekenstam, as Elias before him, sees discipline as the moulding of the body, an attempt to create order through embodying unquestionable obedience. Following Ekenstam, toddlers were systematically trained in

obedience to enhance discipline and character formation in Sweden from 1700 and onwards (Ekenstam 1993). As a malapropos, the phrase 'bodily moulding' is used as a term in Mensendieck physiotherapy. The concept of moulding originate with sculptress and doctor Bess Mensendieck who wanted to mould living bodies in the same manner as she moulded sculptures, through postural exercises and physical education.

Ekenstam calls attention to the historically interwoven dimension of cleanliness, hygiene and high morals. A disciplined personal front, dressing neatly and cleanly, making sure one's nails are kept short and clean, that one's hair is clean and arranged, teeth brushed and so forth, are associated to high moral standards (Ekenstam 1993). This ties in with Goffman's argument that our self presentation takes on a moral meaning (Goffman 1963b). As Ekenstam explains, self presentation includes producing and sustaining personal order, and literally and metaphorically keeping dirt at bay. When the personal front appears too disarranged, or 'dirty', health care agencies as well as relatives and friends, may increase social distance, and alienate themselves from interaction with the disarranged person (Sudmann 1998).

Embarrassment

Speaking with Goffman, complying with social order or behaving disciplined are means of avoiding embarrassment, as Isaksen alluded to above. Goffman's essay on embarrassment and social organisation is of particular interest to issues of neatness and cleanliness (Goffman 1967:97-112), as is his essay on situational proprieties (Goffman 1963a:193-7).

Embarrassment is an experience of emotional disturbance recognisable in others and selves as for instance blushing, fumbling, stuttering, trembling voice, sweating, blinking, tremor of hands and so forth. An ideal typical perspective is that it is only natural to be at ease during interaction, and that embarrassment is a regrettable deviation from the normal state of affairs. Goffman on the other hand, suggest that embarrassment is first and foremost social, and has to do with unfulfilled expectations (1967:105). We cannot have face-to-face encounters in workplace, shops, schools or therapy unless we have some expectations about how other people will behave (Billig 2005:217). When a discord emerges in social interaction, a gaffe or faux pas, the individual responsible for the incident may feel flustered or embarrassed. We

are likely to feel embarrassed when we strike a false note in front of an audience, and less when we are alone. According to Billing's review of the topic, people are more likely to feel embarrassment in front of strangers or acquaintances than in front of close friends and family (ibid.:218). Goffman contends that there is no social encounter which cannot become embarrassing to one or more participants, giving rise to an incident or false note (Goffman 1967:99). Any situation is merely a communication possibility – if the proprieties of the situation are met (Goffman 1963a:196). Embarrassment is further discussed in chapter eleven.

If physiotherapy equates touch and physical proximity, as the last chapter assumed, self-attendance becomes extremely important. Leisure wear, tracksuits, school or work clothes, beach togs – what to wear when you attend a physiotherapy appointment is never haphazard. Efforts taken may be strengthened or undermined by smell or odour or scent. According to the participants in this study, the goal is to dress 'naturally' in such a manner that the effort that goes into dressing is 'invisible'. Furthermore, it implies to prepare oneself for nudity, and control bashfulness. There is a subtle difference between appropriate and inappropriate dressing: taking care of own bashfulness, attending to the therapist's bashfulness, balancing and combining clothes and scents from the dowdy to the provocative, personal appearance, balancing flirting and consideration, overdoing and understating, age-grade and gender.

Neat and clean women

When the discussion turns to clothing, the A-ladies are quick to laugh. They recommend a dress code with a sports bra, shorts when it is hot (on convalescence abroad), and clothes that are easily removed and put on. An additional recommendation is to consider beforehand how far you are willing to undress, no matter the therapist's requirements. Laced briefs or g-string briefs are out of the question, as they are women past their prime. Alexandra recounts an unfortunate incident with therapist PhX.²⁸ Laced lingerie and allusions to PhX make them laugh.

Annabel – you don't wear laces at the physiotherapy clinic (...) it's practical, easy to undress, easy to dress, you might have to return to work afterwards

²⁸ This particular therapist and Alexandra's particular experiences are fully discussed in the next chapter, chapter nine.

mFA? – you don't make yourself sexy (*laughter*) to the therapist, it's neat and clean, my therapist is female, so I don't know

As the A-ladies, the B-ladies are particular about being neat before seeing a doctor or physiotherapist, although they are less shy today after years as patients and visitors to the therapy pool. As one of them says, 'I have to watch my briefs. When I start undressing everything goes off because I'm used to undressing for the pool.' Another argues that if she feels neat and clean, and properly tidied up, she does not care whether the therapist is a man or a woman. Accordingly, if social expectations are met, no one is embarrassed. Britney reminds us of the changes the last decades have brought – among them a bathroom in every house, new modes of interaction between parents and children. 'Nowadays family members are accustomed to see each other naked. In the past, you didn't see a nude adult before you were married' she mirthfully tells us. The implicit rules governing nudity, age and interaction differ from family to family – also in contemporary society. In addition, being raised in different families at different times and locations, and disciplined to embody local customs, our memories are likely to differ as well.

Britney – I remember, if I was to undress in front of the doctor, of course you have decent underwear when you see your doctor, at then, it's so long ago, my body shape was good, but I didn't feel comfortable at all, no I really didn't, but I got cured, indeed

mFB? – we anticipate a professional relation to our body, when we are in a situation where we have to undress

Being neat, and trusting the healthcare providers' professionalism, are critical. The making and sustaining of an asexual frame is of the greatest importance – even though all constraints actually can be read as an appropriation of the gendered and sexual dress code. By asserting asexuality, they are nevertheless enacting the sexual order; keeping things clean, tidy and ordered. Following Dorothy Smith's questioning of the everyday world as problematic, the making of an asexual frame depends on the sexual frame, and this interdependence becomes more prominent when asexuality is stressed. In other words, the more we try to cover up sexuality, the more visible it may become (Smith 2002).

Sassatelli's study of the social order and culture within fitness gyms, forwards an approach to dressing which is most relevant to my study. She has adopted a Goffmanian perspective on interaction (Sasatelli 1999). Physiotherapy clinics, as fitness gyms, are relatively separated

from everyday reality as specialised spaces. Here the bodies may be prepared for different daily routines and yet the operate on the basis of the local rules which translate and filter the relevance of these situations (ibid.:229). The gym, or therapy clinic, is a world in it self. As the individuals attending the gyms, the participants in my study are preparing themselves to transgress from an outside world to the inside of physiotherapy. Sassatelli identified the changing rooms as the 'liminoid' space, organised to facilitate institutional passage. The changing to other clothes is not a requirement of training, it is a fundamental symbol of having entered the new world – the tuning off the outside, and tuning in to what have to be done (Sassatelli:232). Changing rooms thus index training, and reduces their potential equivocality – they provide involvement shields and alternative frames (Goffman 1963a:38-42;Goffman 1974). Along this line of argument, the women's deliberations and concerns with clothing can be interpreted as passage rituals – preparing themselves for another word, loosely coupled to their everyday world, but with its own set of rules or situational proprieties.

When telling about the subject matter of my study to friends, acquaintances or students, they often answered with reference to personal experience, anecdotes or folk lore. Women tell they shave their legs, armpits and 'bikini lines' before seeing a male therapist. In the summer holidays many women shave, reducing or skipping over it altogether in autumn and winter. If they are seeing a male physiotherapist, both body hair and underwear are given a makeover. They worry about cellulites and surplus spread, worry for undressing and to subject themselves to inquisitive gazes. In several of these stories, women find the personal and bodily costs of self-presentation or passage rituals too high, outweighing the benefits of therapy.

Bras and briefs

Cindy – I found this incidence peculiar, I had made my mind up about nudity as natural to therapists

Carmen – and then he suddenly make a comment

Cindy – yes, to put more clothes on (...) he meant that since it was my calf, but what if it had been another (muscle) with a muscular attachment in (more intimate area)

Tobba – you felt more naked than you actually were?

Cindy – yes, he wanted me to undress less, I don't know what

Carmen – it became timid the wrong way

Cindy – what was on his mind if I wasn't covered up enough?

Cindy tells the group about a recent incident in which the male therapist asked her to undress *less* at their next appointment. This worried her, which made Cindy re-frame her opinion of physiotherapy. Cindy does not appreciate being half naked, laying bare all her body complexes. As a strategy in this bashful and uncomfortable situation, she convinced herself that the therapist only looked at bones and tendons, and that his mind was not preoccupied with other bodily or sexually related issues. When the therapist makes a point of her nakedness, she felt naked and humiliated. She wore proper underwear, she tells us, female boxer shorts and a sports bra (she could have worn a lace g-string), but still he found it inappropriate. She asks the group if this is some new trend in therapy. Carmen, arguing that the tables were turned, describes her therapist as the timid one; usually it is the patient who is shy. Cindy wonders what the therapist is thinking about her exposing her body, undressing without hesitation. The C-ladies agree that underwear the size of a decent bikini should present no problems to a therapist, apart from therapist mentioned before who didn't like bikinis. I air the idea that their confidence in look-alike beach togs made the therapist uneasy, and Arnhild adds that it is the therapist who makes gender and sexuality relevant, despite the supposed sexual neutrality of the therapeutic setting. In the following sessions Cindy solved this particular dilemma by keeping certain clothes on, and only uncovered her calf by unbuttoning her trousers half way. However, as she says laughingly, it changed her ideas about physiotherapy. The case of embarrassment seemed twisted to her.

Which bra to wear, and what impression to make, are discussed at length by the women of C-group. The discussions are mirthful, humorous with lots of laughter. When you expose your bra to fellow students or therapists, you do not want to wear the same bra two days in a row, Carmen notes. At the same time, you want to make a casual impression, balancing the titillating and the dowdy; 'We're in our 20s, can't dress like old bags, no matter what!' Clothes have different symbolic meaning, and can't be mixed accidental. This point was made by Daisy as well; you can't wear a training bra beneath regular cloths.

Carmen – (...) when I saw this naprapath²⁹ with my shoulder, I had to undress my upper body, then I used a lot of time to decide on which bra to wear so he wouldn't notice that I used a lot of time to decide which to wear, you can't wear the same two

²⁹ Treatment of disease by manipulation of joints, muscles, and ligaments, based on the belief that many diseases are caused by displacement of connective tissues.

days in a row (*laughter*), that's a dilemma, and I'm sure he can't recall the colours or anything, but I know exactly which I wore each time

(...)

Carolyn – if it had been me, I would've chosen one that didn't uncover too much, but not a dowdy one, just ok

Catherine – you're an athlete, right, it's not unnatural to wear a sports bra

Cindy – but if you're not on your way to a work out or a training, then it's unnatural to wear a sports bra beneath regular clothes

According to the women in the A, C and D groups, on the average, men usually don't notice the difference between an expensive and a cheap bra, as most women do. Women police each other in the “underwear department”, spotting the difference between cheap and expensive underwear and judging contextual appropriateness. ‘The boys’ glances are of less importance than the girls – they police each other all the time, you are more observant of the girls’, Carmen confesses.

Real or synthetic black silk and/or lace are often associated with sexuality and promiscuity – and night clubbing. This argument implies that women worry that some men might misunderstand or ascribe a different symbolic meaning to a bra than intended. Hence a delicate dilemma may arise – you dress according to a code women see as appropriate to the occasion, but the male therapist may misunderstand, or even worse, turns down an “invitation”. For the women, to be turned down without having passed on an invitation creates an awkward and embarrassing situation. Social expectations from the therapist are not met. The conversation below is about black lace. Daphne tells us that she prefers black and jokes with Arnhild about its appropriateness – which they do not agree upon.

Daphne – black laced bra, of course, why shouldn't I wear that kind?

Arnhild – at the therapist's?

Daphne – I always wear that kind of bra!!

Arnhild – I'm just asking ...

Daphne – I'm just answering!

Roaring laughter

Tobba – (...) a lady told me, her old black laced bra was for everyday use, but the male therapist misunderstood, she felt she had dressed casual, and he saw night club clothes

Daphne – no I'm not that sophisticated

Roaring laughter

Conversations about bras and the wearing of bras, are ways of handling cultural stereotypes about sexuality – both in terms of the reproduction of stereotypes and subversion of them.

Breasts are supposed to be visible and invisible at the same time – naked or half naked

women on billboards and in TV commercials, while remaining titillating covered in private. According to Bjelland, breasts are the most public part of women's private parts. Their sexual connotations are confirmed through mediated sexualisation. Breasts are reproduced as erotic, sensual, poetic, over/under-sized, 'food stores', and as medical organs (Bjelland 2006).

Covering the breasts too much is dowdy³⁰ unless it is a sports bra, according to the young women of C-group. Being old-fashioned has no direct correspondence to age; it's rather a non-appreciated non-feminine state of being. With increasing age women are less desired as objects of public fe-/male gaze, and do not have to make the same effort to keep up with contemporary ideals of ornamentation and performance. None of the group conversations produced or aired subversive opinions or experiences about bras or briefs; e.g. playing with the symbolic meaning, teasing the therapist, flouting customs. All the women had thought of bras and physiotherapy more than once. This is a telling fact.

According to anecdotal lore at the college, senior physiotherapy students once welcomed the freshmen by undressing their t-shirts (keeping bras) while singing a song. The choir was made up of about 50 students, and was watched about 60 newcomers. The spectacle brought audible sighs from the audience, and laughter from the older students. The newcomers were taken aback, and the girls displayed their anxiety about walking around "half naked" in front of the boys. The story elicits a burst of laughter in the C-ladies group. The surprising element of the spectacle and the reluctance to uncovering one's body in front of strangers are appreciated by the group. Further on, the story goes that after a while being "half naked" is a matter of habit.

This section on bras and briefs illustrates Goffman's arguments on embarrassment. Above the women tell of fluster and uneasiness – and henceforth embarrassment. Even though they all pay attention to and prepare for entering the world of physiotherapy, they experience that any situation hold the potential of striking a false tone. Underwear is scrutinized in many situations, and the proprieties differ across them. Involvement in therapy presupposes that the interactants manage to create a situational definition. When the patients become embarrassed, the therapist might be as flustered as them, or even worse. The ones, who have tried to be

³⁰ In Norwegian: tantete

tactful, and recognise that they have discredited some of the others, also discredit themselves (Goffman 1963a:106). If both are completely flustered, the interaction breaks down. However painful these experiences might be in actual time, they are regular incidents of social life. Billig's reading of Goffman's argument suggests him to launch embarrassment as the key to reproduction of social order and culture (Billig 2005). Conversely, when social expectations are met, embarrassment is avoided, and social order is reproduced.

Precautious self-attendance

Changing clothing to enhance transgression from the everyday world to the therapy world is not an undertaking in a vacuum. Acknowledgment of the efforts remains crucible. An example from Doris shows how dressing up might be difficult when you need to dress for two incommensurable arenas – e.g. school and therapy – and have few possibilities to carry along double sets of clothing. Doris tells us how her two therapists, a man and a woman, made choices for an appropriate therapy context. Doris never knew beforehand which of them she would meet. The male therapist let Doris choose where the therapy took place herself, but she felt that the female therapist looked first to see whether Doris was dressed for the gym, i.e. to be in the public gaze, or for a more sheltered setting (the separate room).

Tobba – did you plan your clothing to avoid being exposed?

Doris – no, I thought, I hope it's him today, I came directly from school, right, and so I came dressed in my school clothes, right?³¹

Her strategy was not very effective, and when she remarked about how she said prayers, there was lots of laughter in the group. The group appreciated her attempts to take control, but also laughed with her at this hopeless project. Later in the conversation Doris said she was too young to have much control, or make objections to the set-up. Age is an important dimension, both as lived years, and as years past with professional assistance and treatment. As you grow older and wiser, resources are redistributed to create a personal body politics, where negotiating the premises for therapy becomes possible.

When in therapy, there is little time or space for circumstantial clothing. Dressing and undressing must be rapidly done. Few therapy centres provide separate changing rooms. When we talked about underwear, Daniela repeats a popular saying – always wear clean

³¹ Casual dressing of individual choice, no school uniforms in Norway.

underwear because you can be in hospital before you know it. Mentions of this cultural anxiety for dirty underwear elicit laughter. It is probably rooted in an anxiety of not receiving necessary help in an emergency (or everyday) situation, being denied help or care because we are dirty. As already discussed, personal self presentation takes on a moral meaning, e.g. being judged a worthy or non-worthy recipient of care. We lose 'face' when we give off signs of our inability to keep order. This lesson is well thought through, and "everybody" confirms the existence of a cultural notion of tidiness, even though we never know exactly how it functions in specific situations. Hence, we act upon it in advance, as a safety first strategy. Goffman alludes to this issue when he observed that a typical sign of an oncoming psychosis or otherwise exacerbating condition seemed to be followed by increasingly neglect of personal attendance and hygiene (Goffman 1963a:27). Personal front takes on a moral meaning. And along the same lines we expect a proper treatment if we fulfil the expectations of situational proprieties – even if we are run down by a car.

Neat and clean men

Being neat and clean is an obvious requirement from a male point of view as well. The A and B-gentlemen tell they have been brought up to clean and dress themselves properly before visiting a dentist or physiotherapist. The extract below shows a certain amount of disagreement about what neatness and cleanliness actually mean in practice. The A-gentlemen's exchanges are mirthful, there is lots of laughter, chuckling and grinning.

? – and arriving smelling sweat, and then they finish before even started

Laughter

? – pay before you reach the door, and then leave

? – yes, yes

? – that's automatic, you ain't attending in working clothes

? – change to

Tobba – are all of you thinking like that?

Anthony – anyhow, you wash, shower, neat and clean, whole underwear, and the works, I don't think about it, it's just the way it is

? – my mother in law, she thought of that all the time, what if you ended at the hospital

? – that's the same as my mother in law

Laughter

? – something might happen

Tobba – my grandmother told me the same, dress like this, something might happen

? – end in hospital

? – run down by a car, but clean underwear, that's important

Laughter

Asgeir – the worst story I heard was told by a friend, he fell of the ladder painting his house, and his wife took him in the bath tub and cleaned him before he landed at the hospital

Laughter

Asgeir – he couldn't appear in paint

Tobba – this is imprinted in us from childhood, if something happens, we must be neat and clean

Bashfulness, neatness and cleanliness are related. Violating a notion of respectability either by being dirty or promiscuous elicits a fear of sanctions – of not being welcomed at the hospital, of not receiving proper treatment. This group of men slightly beyond their prime, laughed at mothers-in-law, wives and mothers, and their tendency to fuss about cleanliness. These men, as the women above, are drawing on a common interpretive background, where cleanliness, hygiene and moral standard are intertwined. Following Goffman, the scriptures of situational requirements are of a moral character, and the individual are obliged to follow them (1963:240). Goffman suggest that women are more tightly defined than men. He refers to a popular belief that the female toilet takes longer than the male, and that therefore more is entailed in making a female presentable than making a male presentable (ibid.:204). The groups with women made a lot more fuzz about underwear and dressing, in terms of spending more time discussing the topic, and in terms of laughter. If Goffman's argument on embarrassment still holds true, as Billig (2005) suggests, then women's lingerie and dressing is highly charged with possibilities for false notes, flusters and embarrassment. The extracts above and below lends support to this interpretation.

Respectful male dressing

Being neat and clean is one way of showing respect to the people who are going to work on you; it is a common courtesy, according to the C-gentlemen. It is like brushing your teeth before you see the dentist, because if you don't your dentist may not want to see you again. Sometimes the athletes pop into the changing room if they are worried about a hole in their boxer shorts before seeing the therapist at the sports ground. As athletes, they can go to therapy in training clothes, but they as a rule of thumb scrutinize and measure their appearance against the appropriate dress codes.

? – not the boxer with the biggest holes

Tobba – but if you have a sprain in your gluteus muscles?

Carl – you are not attending in string-briefs anyway, it depends on how well you know the person, may be not the most dirty boxer

Charlie – you have to behave clean, I think, it's a consideration towards the therapist, otherwise they dread to see you again

Conrad – it's common politeness, like brushing your teeth before seeing a dentist

Chris – we are running in from training, they are used to it around here

(...)

Charlie – I got burned on that once, remembered I had a hole in my boxer, then I ran back and changed to a football shorts

(...)

Tobba – but what is the male parallel to black laced female lingerie?

Charlie – the male instinct starts to work, and he think, don't think, and still it's there

Asgeir took the discussion of underwear further, to a subject which animated women in particular. We wanted the male athletes to teach us the male dress code. They talked about something else in the event, but an interesting matter all the same. Charlie reflects over the role of the male therapist, whose female patient arrives wearing black lace lingerie, presumably understood by the therapist as sexy underwear. Sexy underwear stirs up the male instincts, Charlie argues. He believes the therapist tries to suppress the sexual connotations, but that they continue working subconsciously. Accordingly, Charlie explains the female athletes' efforts to balance their dress code. If choosing the wrong underwear, his argument indicates the risk of destabilizing the image of asexuality, and disturbing the interaction. However, male bodies can be desired by the therapist, regardless of underwear. This topic was discussed with the C-gentlemen, and will be followed up in chapter eight on gender.

A question remained unanswered; is there any parallel situation where men risk challenging the situational definition by violating a dress code. The symbolic gender order ascribes different signs for 'sexy' men and women within a heterosexual frame. Men are objectified through women's gaze, and vice versa, but their position in the system is different. Men are more often displayed as the active desiring party, and women as the passive and desired one (Goffman 1979). However, Crawford noted several limitations to focusing on gender differences (Crawford 1995). An identical match in 'situatedness' is impossible to detect. Men and women are met with different social expectations and reactions. Following this lead, male underwear cannot be construed as a direct parallel to women's. It is not the underwear *sui generis* that is at stake, but how the social institution of gender enables and constrains any social situation and the meaning derived there from. Clothes are but many signs that feed into the situation.

When the athletes encounter their therapist, there is no particular need for “passage rituals” as the women above told of. The therapist belongs to the training facilities – and the passage through the changing rooms by and large indexes training. The males are well into the world of training before they encounter any therapist. The courtesy of checking up on clothing is done to avoid offending the therapist – and create an embarrassing situation for both.

A standard regimen

Below the male participants in the D-group discuss dressing and preparing to attend a therapy session. They do not agree upon the issue:

Desmond – well, it is a point, you do consider how much you are going to undress, and then consider which underpants to wear, you run a standard regimen

Tobba – neat and clean

Desmond – yes, and the same at the Doc’s

Duncan – and if it’s a woman or a man, it is the same procedure, I don’t think that matters

David – I would have made some extra effort if it was a woman, of course I would have done what is expected to a male as well, but might add an extra

Duncan – at least if same aged

David – yes, fragrance and stuff

Laughter

Donald – is that your way of flirting or making a pass?

Laughter

David – no, no

Donald – it must be of no matter whether you brush up for a man or a woman, if you’re going to the therapist, no matter if the shirt is blue or white

Duncan – if it’s clean, you mean?

Donald – as long as I’m attended to

David – no, that

Donald – I’m not changing clothes, regular clothes, might take a shower (...) I just want them to start, and then I’m finished with that matter (...) I’m not dressing any different

David – it depends on the chemistry

Desmond – I have to confess I have different kinds of underwear, some of it has a loose thread, other a whole, and I do not put on the one where everything is falling out, it’s not stupid to make these kinds of considerations

Donald – then you show an interest in the others

(...)

Donald – you have to dress natural, not exaggerate, then the whole point is lost, I think

Desmond – but it’s ok not to understate either

Laughter

Donald – dress in everyday clothes, if they won’t take me on

Tobba – then they must manage without

Desmond – they are getting their due pay, anyhow

The need to keep oneself neat and clean seems to be accepted by all, but the practice and perceptions of standards differs. Donald argues that he attends physiotherapy in the clothes he happens to have on and the condition he happens to be in on the day in question. He argues that if you attend too much to your appearance, you are indirectly making a pass at the therapist, or signing a desire for some kind of inappropriate attention. Take me as I come, is his credo. Accounts that at once are defensive and assertive are often offered when personal worth is being challenged (Radley & Billig 1996:226). If Donald wants to induce the others to regard his actions as worthy, then he must link them to motives and actions that are seen as culturally “normal” and worthy. He justifies his claims by connecting overdoing personal appearance with making a pass at the therapist, which is not culturally acknowledged. As Radley & Billig states, in this way an ordinary person who struggles to maintain ordinary standards explains why higher standard are impossible (ibid.).

Desmond confesses his collection of underwear is a very mixed bag, with the choice of what to wear depending on the situation. He argues that considerations of this kind will always come in handy, whether you visit a doctor or a physiotherapist. David has consistently maintained that to him, a woman’s touch is different from a man’s touch, and that he prefers the female variant. He says that he changes his appearance according to the sex of the provider. The D-gentlemen do not come to any consensus on these matters, and Desmond’s comment about not underestimating the importance of looking neat and well turned out, may be read as a corrective to Donald to pay more attention to his appearance, and show a bit of consideration for the therapist. Contemporary “beauty market” is increasingly directing their advertisements towards men, and men are spending more time and money on self-attendance. Desmond’s comment may allude to these trends, and imply that increased self-attendance first and foremost increases personal well-being, and secondly avoids offences and embarrassment.

Dressing up order

According to Almenningen, a proverb is a short pithy saying in frequent and widespread use that expresses a basic truth or practical precept. The proverbs serve as a guide or generic knowledge, and hence also represent a moral, or rule to live by, for people through history

(Almenningen 2005:9-10). The proverb or saying 'always wear clean underwear, you might be in hospital before you know it' was introduced by the D-ladies and A-gentlemen, is suggestive. Being hospitalised these days means that your life is in danger, unless you get professional help. The proverb connects professional life saving treatment and decent appearance. Vice versa, one's life may be at risk if you neglect to take the necessary precautions. Every now and then the papers bring of stories about people who were refused due negative interpretations of their personal appearance ("looked like a drug abuser"). Whether a patient or not, ideally, people try to keep up with accepted standards of "presentability and cleanliness" to the best of one's ability. However, illness or disability may limit one's capacity, causing divergence from socially accepted practices. Care of the self is often neglected when problems related to e.g. drug abuse or psychiatric ailments are getting out of hand.

The neat and clean script creates the idea of an asexual interaction frame, which subsequently makes lingerie and underwear displays possible. Nevertheless, all the considerations associated with a neat and clean appearance affirms the sensual nature of the tender bodily encounters in physiotherapy. Self presentation is rhetoric; there is dialectic interdependence between dirt and cleanliness, and between sexuality and asexuality. None is possible without the other.

Mary Douglas's notion of dirt as matter out of place resonates with the neat and clean practices. If we, as patients, seem out of place because we look dirty, the social interaction comes to a halt. Being dirty, e.g. being sweaty and smelly, having stains on one's clothes, dribbling or having untidy hair, allude to the persons' capability to keep up with socially accepted deference and demeanour. Even when granted exemption from ordinary claims, the sick role do not grant permission to flout self-attendance. On the contrary, the sick have a plight to regain health, which implies interaction with health care agencies.

A disruption may occur not because of the smell or the stains in themselves, but because one's appearance deviates from the expected in such a degree that it is difficult to ignore. Efforts made to ignore such signs, may even amplify them, transforming them into symbols of 'deviancy'. Conversely, exaggerated tidiness can disturb interaction as well, if it is

impossible to ignore. When some of the signs we deliberately give, or unwittingly and uncontrollable give off, are sounding like a false tone or faux pas, the interaction comes to a halt. Social interaction can not be postponed, it either comes into play or it temporarily disrupts. The conditions for a communicative situation are changed. Gadamer, however, is emphatic to state that a conversation is always possible – because we cannot name a communicative disruption without reference to a conversation in play. Language is rhetoric and hence dialectic, every sign has a negation. Even though embarrassments emerges due to situational improprieties (“otherwise life would be clogged” Goffman 1963:240), we can resume communication and come into play again.

Closing remarks

So far, the participants has imparted that if an encounter between a patient and a physiotherapist is to come off, a common ground and working consensus must be established through spoken and bodily communication and dialogue. An important enabler and constraint upon interaction and communication is self presentation, particularly neatness, cleanliness and clothing. Self presentation, on behalf of the patient, is planned to details to minimise chances for misunderstandings or ‘loath’ on the therapist’s behalf, and to enhance the possibilities for a dialogical and touch-based interaction to come off. The aim is to meet social expectations and live up to propriety standards of therapy. Gender, age and therapeutic context imprint the choices made. When social expectations are not met, the patient experiences embarrassment. Embarrassment also emerges if the patient finds that the therapist relates to other sets of social proprieties than the patient believed where expected.

The next chapter turns to gender as an accomplishment, as an institution and as agency.

8. Gender; accomplishment, institution and agency

The previous chapters on dialogue and touch primarily circled around how a definition of the situation was accomplished by means of spoken, non-verbal and tactile communication facilitated or inhibited by presentation of self. This chapter turns to one of the background resources available to the interactants; gender. Resources as gender, or age and disability, are employed as talk, as action, and as interpretive schemes. These resources are used for different purposes and situations to negotiate therapeutic encounters.

Goffman's meticulous studies of social organisation and interaction made it possible for him to forward a critique of classical gender role theory and biological determinism (essentialism). As Goffman notes in the introductory paragraphs in his essay *The arrangement between the sexes*:

Women do and men don't gestate, breast-feed infants, and menstruate as a part of their biological character. So, too, women on the whole are smaller and lighter boned and muscled than are men. For these physical facts of life to have no appreciable social consequences would take a little organising, but, at least by modern standards, not much. [...] More to the point, for these very slight biological differences – compared to all other differences – to be identified as the grounds for the kind of social consequences felt to follow understandably from them requires a vast, integrated body of social beliefs and practices [...] It's not, then, the social consequences of innate sex differences that must be explained, but the way in which these differences were (and are) put forward as a warrant for our social arrangements, and most important of all, the way in which the institutional workings of society ensured that this accounting would seem sound. (Goffman 1977:301-2, (round brackets) in original)

Goffman's student Candace West suggests that the three first sentences dispenses with entire libraries' worth of justification for women's oppression. Goffman moved beyond contemporary theories, and reconceptualised gender from the angle of public order and the social situations that sustain it (West 1996:362). In the late 70ies, Zimmermann & West coined gender as an accomplishment, as an achieved property of situated conduct (Zimmerman & West 1977). If gender is an accomplishment, our attention shifts from matter internal to the individual and focuses on interactional and, ultimately, institutional arenas. Rather than a property of individuals, they conceived of gender as an emergent feature of social situations: both as outcome of and as a means of legitimating one of the most fundamental divisions of society (West & Zimmerman 1987:126).

Following this lead when inquiring into the matter and meaning of gender one has to question how social beliefs, practices and social institutions are both background resources and interpretive schemes. As Goffman implies, believing is seeing, and difference is doing. Or in Gadamer's wording, interpretation is a game in which one has to go along with the meaning in which one participates (Gadamer & Grondin 2006:375). And more, the meaning-constituting background is directly tied to providing rules and resources for the consciously acting and reflecting subjects (Kögler 2006:204). There is no Archimedean vantage point available to participants or researchers – we participate in the meaning of gender while doing it as intentional beings.

A few paradigmatic experiences are used as point of departure for this chapter. Kögler reminds us that any understanding of another agent and her symbolic expressions is; a) based on some interpretive scheme; and b) nonetheless bound by the presuppositions that we are dealing with an intentional expression (Kögler 2006:209). The ontological premise of this study states any human being as intentional. In this thesis, these intentional expressions are described as agency, as the condition of being in action, and the means or mode of acting, building on understanding of the situation at hand.

Gender displays

In *Gender advertisements*, Goffman summarises many of his previous arguments on social situations, where people are present in a perceptual range of each other, coining the concept gender display.

Assume all of an individual's behaviour and appearance informs those who witness him, minimally telling them something about his social identity, about his mood, intent, and expectations, and about the state of his relation to them. [...] one can call these indicative events displays. As suggested, they tentatively establish the terms of the contact, the mode or style or formula for the dealings that are to ensue between the persons providing the display and the persons perceiving it. [...] If gender be defined as the culturally established correlates of sex (whether in consequence of biology or learning), then gender display refers to conventionalised portrayals of these correlates. (Goffman 1979: round brackets in original)

Current gender/feminist studies seldom draw on Goffman; they are more taken with and indebted to Michel Foucault and Judith Butler. Interestingly though, Goffman's analysis of gender as a naturalisation of repetitive practice, more than resembles Foucault's discourses, practices that systematically form the objects of which they speak, as it does Butler's stylized repetition of acts through time, a performative accomplishment (Butler 2004a:154-5;Foucault 1972:49).

Displays are genuinely dialogical; it is an interchange of statement-response or question-answer interchange, and interpretation. The individuals in receptive distance give and give off, and receive, information about each other. The interchange may be verbal or non-verbal, but always mediated through the body – even when on telephone. Some things go without saying, early warning signs given off like names, hairstyles, voice, clothing and so forth. Displays are more often than not multivocal, several snippets of social information may be encoded, and different hierarchical statuses can be invoked in the same display – a feature often exploited by the participants, and well known from studies of (gendered) interaction, as another of Goffman's students, Deborah Tannen, implies in *You just don't understand. Women and men in conversation* (Tannen 1991). However, people can be quite conscious of the displays they employ, and be able to perform specially designed displays for carefully selected contexts. Societal members “use gender” or borrow gendered expectations to create and legitimate social relations (Martin 2004:1266). An individual has little option regarding their biological sex, but can stage displays which confound application of a sex category, as well as making a disruption in normative conceptions of attitudes and activities. Communications devoid of living bodies (e.g. e-mail, sms) are not captured directly by Goffman's displays, even though they are staged and situated with reference to social and cultural practices.

Goffman comments the ritual-like structure of gender displays, and calls attention to how the parent-child-complex (in its ideal middle class version) serve as a fruitful source of behavioural imagery. The main point is that the parent-child complex is a social hierarchy, distributing resources, plights and rights in favour of the superordinate person. Goffman observes that males behave towards women and subordinate males in much the same way as adults behave towards children. The same goes for women's behaviour towards subordinate

women and towards children. This parent-child complex is a common fund of experience – we have all learned about gender-hierarchies by growing up amongst sibs, parents, friends and relatives – which we seem to draw on in a fundamental way in adult social gatherings (Goffman 1979:5). The contemporary construal of this is a heterosexual hierarchical order between dominant men and subordinate women – accounting both for sexual interrelationships as well as social relations between strangers or friends. Goffman summarises the case as follows:

In sum, gender, in close connection with age-grade, lays down more, perhaps, than class and other social divisions and understanding of what our ultimate nature ought to be and how and where this nature ought to be exhibited” (Goffman 1976:8)

Goffman’s argument was built on his observations and experiences up to the 70ies. Whether his argument holds true or not to day, there have been substantial changes in child raising and house hold cores both in the USA and in Europe since then. Hierarchies are challenged, negotiations cut across gender and age in most families, and as a rule of thumb both parents are part of the work force. However, following Arlie Hochschild, another of Goffman’s students, there is reason to believe that Goffman’s main argument still holds true (Hochschild 1996;Hochschild 1997;Hochschild 2003;Hochschild & Machung 2003).

What is it that’s going on here?

The heading of this section is a classical sociological question to any situation, often repeated in Goffman’s writings. A corresponding answer from Gadamer would be that “Hermeneutics helps us to realize that there is always much that reminds unsaid when one says something. There is a lot in the same direction of meaning that almost completely escapes our attention (..). Thus I have designated as a central point to hermeneutical procedure that one is never to have the last word” (Gadamer & Grondin 2006:91). The following sections of this chapter will pay heed to both Goffman’s question and Gadamer’s cautioned answer – and offer some interpretations of the stories told in the groups.

The long extract below demonstrates the multivocal displays of gender, performed in an intimate and significant cross-sex relation between a female patient and a male physiotherapist. Some of the women and some of the men in this study, have experience of or

had heard about this particular male physiotherapist, hereafter called PhX. The cases are interesting because they surfaced so often during the session with the A-ladies, each time eliciting huge amounts of laughter.

Alexandra – there was this incident, 25 years ago, I had a back-problem, and I had never seen a physiotherapist before

Tobba – were you dreading the encounter?

Alexandra – no, I didn't dread it, but when I came behind the curtains, in my briefs only

Amy – tell about the stairs

Laughter

Alexandra – there's a nice lady, in her 50s or 60s, it was winter, she had a beautiful fur coat, and she was in a terrible hurry, got the coat on, reddish in her face. "You're in a hurry", I said, and then I went up the stairs to this therapist. "Get undressed", he said. He let me keep my briefs on, and there we stood in front of that mirror, he behind me, and his hands, everywhere, above and below of my briefs

Tobba – did he touch beneath the briefs?

Alexandra – not then (*laughter*), I was to lie down on the bench, it was close to the wall, you laugh, do you know where I've been?

Lots of laughter

Annie – it was terrible, I stopped seeing him

Alexandra – but beneath the bench there was a socket, so he pulled the bench, put the machine between my legs, then he bent all over me and plugged

Tobba – and then it started?

Alexandra – the machine started, and I hit, I gave him a smack that gave him ringing in the ears, and off he went, and me to, I never heard anything since

Laughter

Alexandra – that was my first experience with a male therapist, and I didn't want that to happen again

(...)

Annabel – this one, he fumbled on many women

Alexandra – (*roaring laughter*) he's dead now

Augusta – it's probably the same

? – he was clever they said

?- I did not want to see him

(*Lots of laughter and laughable comments in the background*)

Alexandra – it was the one clinic available, the others were full

Tobba – but didn't he earn himself a reputation?

Alexandra – he did

? – yes, yes

Annie – I made a complaint to my GP

Alexandra – my GP wanted to file a formal complaint, but it's impossible, you're alone in a cubicle, its claim against claim, it couldn't work

Annie – he was disgusting

(...)

Annabel – it was almost like attending a gynaecologist, you dreaded the sessions, when you undressed, he said I smelled so nice

Alexandra – my God, now I can laugh, but not then

Lots of laughter

Tobba – it's Ok to laugh now
 Annabel – I had a colleague, she warned me
 Alexandra – so you were prepared (*laughter*)
 Tobba – but if you had been warned, what then?
 Alexandra – I'd never put a foot there
 Annabel – but you had taught him a lesson at once, I did
 Alexandra – yes, ok, no, I'd not gone anyway
 Tobba – but how did you teach him a lesson?
 Annabel – I stepped back when I undressed, I told him, "This is enough undressing", I said, "why undress more?" "Because I want to see your back", he said
 Alexandra – he told me to undress, so I undressed everything
 Annabel – no, this enough I told him
 Alexandra – but if he should see my back, that obvious
 (...)
 Tobba – is this something everyone knew?
 ? – yes, yes (several voices)
 Alexandra – that I didn't know
 Angelica – neither did I
 Tobba – is this only a women's secret?
 ? – (many) no, no, no
 (...)
 Alexandra – it's nice to have so many women around, you think you're alone
Laughter
 ? – oh no, you are not alone in this

The A-ladies are quick to laugh whenever an indirect or direct reference is made to physiotherapist PhX, as in the extract above and repeatedly during the group conversation. What is it that's going on here? What are they talking about? Why are they laughing so much? Does this group of women differ from other female patients PhX might have treated at his clinic? Or is the difference to be found within the research groups? Male participants may have different experiences, and other female participants may lack such experience altogether. They may have been treated differently by the therapist, or their experiences are muted by the group construction.

A first analytical approach to understand these experiences is to take a step back, and look more closely at the dialogical dimension of the interaction – expressions given and received, displays performed and witnessed – as small behaviours. Playing on Goffman, I re-coin some of his concepts, and propose three theoretically constructed strands along which to pursue my inquiry into gender; *celebrated* gender display, *multivocal* gender display, and *declined* gender display, all strands associated with different age-grades. These strands must be understood as analytical constructions, as tools for interpreting experiences where gender is

particularly salient. Goffman's gender displays are frames for analyses. The practices observed constitute gender as a social institution – as repetitive practices and interpretive schemes. Accounts given about any issue or practice evoke available cultural resources. These resources provide generic expectations and explanations – as Goffman eloquently has demonstrated. However, any concrete and particular incident or situation can never be reduced to a generic understanding – it is always more nuanced and multivocal when studied in detail. The extract above did not provide many details, and subsequently the discussion in the group – and my analytical constructs – are on a generic (Goffmanian) level.

From late adolescence to late thirties/early forties the sex category of both men and women is a prominent sign, deliberately given, given off, perceived and acknowledged in social situations. Most often, individuals apply easily recognisable signs in their presentation of self to ensure gender placement. It is commonly accepted and *celebrated* that during these years gender is salient; men and women are lustful, they court and mate, and eventually marry, have children and settle down. Accordingly, if a male physiotherapist deals with a young woman, her gender display is always a part of their interaction, as is his – compared with and contrasted against stereotypical conceptions of femininity and masculinity. As a rule of thumb, the therapist, male or female, supports a female patient's gendered display through their conversation or bodily interaction, by simply acknowledging that she is a woman, for the time being subordinated to the therapist, independent of the therapist's sex. Gender displays are acted out during the work that has to be done, e.g. through attire, voice and language-use, courtesies when greeting and bidding patients goodbye. It will follow that if a young woman's gender display is celebrated, she is a fluorescent gendered being, and hence recognised as a sexual being as well. Still, the therapist may opt to decline gender displays. If the person gives off bodily signs that are difficult to ignore, or contradicts stereotypical conceptions of femininity – scars, large moles, malformations, props, smells, untidiness, disarranged personal front – the person's displays may be compared and contrasted to normative conceptions of attitudes and actions. Gender may not be the more outstanding issue.

Beginning in the early forties and into the sixties, the sex of a woman is one of several sign vehicles. It is not given when, why, by which means or to which ends her gender is made

relevant, or her age, class or other statuses. Gender is in a transition between being obviously present and celebrated, and obviously detached as a prime marker, and hence an optional sign to attend to. As in limbo, a *multivocal* gender is a negotiable dimension that is easily overridden by other signs displayed in physiotherapy: as for instance bodily signs of illness or disorder. For women (and men) around their prime, I presume gender is an important dimension of their personal identity, but at the same time it is increasingly less appreciated as the fundamental sign. It is not given that a woman will be recognised as a sexual being, even if she is recognised as a woman in her late fifties. Within the health service frame, health status, disorder, age, social status and class are likely to outdo gender as primary social sign (NOU 1999:13). Accordingly, we can imagine several scenarios where the interacting parties have different conceptions of gender, without a mutual understanding of ‘what it is that’s going on here’. In these situations abuse and misconduct may occur – beginning with a misunderstanding of consciously and unconsciously mediated signs, and lack of an appropriate frame in which to organize experience.

The last strand is the *declined* gender display. I suggest that when we are well on in years, then age, along with health status and social class, increasingly replaces gender as the predominant social marker. This renders gender, as sexuality, a diminishing dimension of our ascribed identity. Women and men are not primarily identified as sexual beings from a certain age. Having said that, heterosexual display (Goffman’s parent-child complex) may not cease to evoke in the male courtesy or gallantry towards women and subordinate males, and in turn women may accept such expressions of gallantry, or of course decline. The other way around in terms of hierarchy, however, is slightly more complicated. From a subordinated position, women may have to design and enact a particular “hyper-gendered” performance, and plead for a generous reception, if they want gender to be recognised as an outstanding issue. They may even find their efforts are declined. Drawing on the behavioural imaginary of the parent-child complex, the dominant part (e.g. male therapist) has professional access to the patient’s body, and the dominant part has the power to define the situation. Accordingly, the patient’s body can be touched and handled without any sexual connotation – that is, if that is what’s going on from the provider’s point of view. Goffman summaries the case of sexuality as appearing to have a biological cycle, presumably being very little marked in infancy, very marked in young adulthood, and once again quiescent in later years. It seems that beliefs about gender, he contends, about femininity and masculinity,

and about sexuality are in close interaction with actual gender behaviour, and that popular social science plays a part here (Goffman 1977:304).

These three strands are analytical constructs or ideal-types; the boundaries between them are porous. Ideal-types are also historically situated. The analytical constructs are inspired by Goffman's gender displays, coined in the 70ies. Displays evoke interpretive generic background schemes, and do not tell of the living interactants' intentions, experiences or understanding. Furthermore, a narrative about being in your thirties in the 1970s differs from a narrative about being in your thirties in the 2000s. Age is significant when the experience is gained, and when it is retold – as is the age of the audience. A social encounter between people of similar age differs significantly from a social meeting where the age differences are obvious. However, if we apply these broad strands as analytical tools, several analytical proposals can be made. The constructs are tools that enhance multiple readings of troublesome experiences at PhX's clinic. If we return to the therapeutic stage, these three gender strands are intertwined with other social orders – e.g. the ideal organisation of health service as neutral with respect to gender, age, class or other statuses.

Most of the women were at the 'multivocal display age' when these experiences were gained. The age of the therapist is not known to me. Some of the women knew hearsay of 'womanising', others did not. What follow is five different suggestions or to answer the question 'What it is that's going on here?'

First, if a woman expects a gender neutral atmosphere, she would not welcome comments or hints from the therapist which highlight her as a gendered (sexual) being. She would object, and refuse to conform to his definition of the situation. On the other hand, the therapist is in a dominant position, and might still construe her as a sexual or sensual being. A common definition of the situation is not reached, and the woman might experience this as unwanted sexual attention or harassment. Several of the stories recounted above fall into this picture.

Second, if we turn the tables, and the woman presents herself as a gendered and hence a sexual being, and the therapist refuses to acknowledge her self-presentation and display, she

might feel offended, as did her sister in the example above. The therapist's refusal to take her signs seriously reminds her of a hierarchical (gender) order, where the male is the proactive part. The empirical material does not allow me to imply this interpretation of the A-ladies discussion. However, if a woman is acquainted with the rumours, and even finds them titillating, a declination of her as a gendered and sexual being might be felt embarrassing or even provocative. These experiences are not easily raised in a research group of middle-aged women – some of whom have troublesome experiences.

Third, the therapist can perform the gender neutral ideal, acting according to Goffman's parent-child-complex, which gives him unlimited access to these women's bodies. As a scenario, we would expect at least one of the women to have a nagging suspicion, a feeling that he sees her as a sensual and sexual being, and is covertly enjoying her body. This leaves her with few opportunities to object, because whatever she says or does it will be dealt with within the gender neutral frame, leaving her embarrassed. After all, the therapist might just be enjoying his work with any patient of any age Alexandra's 'hit and run' strategy makes sense within this frame. If it was possible, at least as an imaginary scenario, to rise above her personal uneasiness and concern, and concentrate on the actions, the therapist could always argue he was doing what he was supposed to do, if unfortunately in a rather clumsy way. She is nevertheless the one to bear the blame – because she hit on his actions, and allegedly misunderstood his intentions. This is what Deborah Tannen catches in *You just don't understand* (Tannen 1991).

Fourth, the therapist can refuse to acknowledge either age or gender. The therapist may be absent minded during the appointment; he may leave the room several times or stay away a bit too long, creating a feeling in the patient of not being the main issue for the moment. The patients are more like a diversion. When a woman is not acknowledged as a gendered being, as she expects, gender may become even more important to her, often overriding age as the predominant marker – you are caught in the 'fair, fat and forty'³² trap. Or conversely, trying to give a gendered display which is declined increases the importance of age – since age gives off non-verbal signs – as early warnings difficult to negotiate.

³² Førti, feit og ferdig

Fifth, some women may appreciate being acknowledged as sensual and sexual beings in the therapy room. Particularly if they experience that their age-grade alludes to multivocal gender displays, or they are well on in years, some must have welcomed this kind of reception and attention. The comments by the men who knew of PhX are suggestive. Many women were fond of him; he had sex-appeal they recall. However, two or three participants of the research group had personal experience of this particular therapist, and not particularly enjoyable experiences. When they spoke up, any pleasurable experiences in the group were muted. Only the men were able to express these experiences on behalf women in the community. To my knowledge, some of the women present had ambivalent experiences – both pleasurable and less enjoyable. Subsequently, their accounts would differ according to the situation at large.

We do not know if the same things happened to the women who were satisfied with the therapist, or if women in their twenties had disapproved likewise, and not been as surprised as their elder sisters. The PhX case illustrates Gadamer's point, there is never a last answer – you can always look at a case a new, and reach yet another understanding. A better look uncovers further details, and new understanding emerges. The PhX case was briefly introduced, and very few details were shared in the group. A further interpretation demands a better study, which is beyond the scope of this study. I have raised an analytical scaffold to provide support to my suggested answers to the question “What is it that's going on here?” However, such a scaffold inevitably must be dismantled, and to allow new interpretations to emerge – as Goffman and Gadamer would have it.

Gendered intimacy is part of the job, or is it?

Physiotherapist PhX is introduced in the A-gentlemen's group discussion by one of the participants, and I respond by recounting what I had heard from the A-ladies. The men became slightly embarrassed, but countered with stories of satisfied women patients, and stories of the therapist's noted sex appeal. The women were quick to give into laughter when PhX was discussed, but the men are more reserved and embarrassed. Why is this? Recalling the Goffmanian strands of gender and age display above, the A-gentlemen are well on in years. They were aged about forty when the women's liberation movement got under way in Norway in the 1970s, and gender and sexuality became a public issue concerning equal

rights, sexual abuse and oppression. Folk lore on sexual abuse and misconduct draw on stereotypical constructions of sexuality and gendered conduct – sometimes tending to see all men as potential harassers or abusers. Even though everybody knows that very few men are abusers, the undercurrent constructs men as more primitive, less in control of their sexual desires than women. Another folk lore stereotype makes a connection between feminism (a preoccupation with gender in one way or another) and a generic dislike for men. I will never know for sure, but bringing old stories to the surface in the presence of a female researcher explicitly preoccupied with gender in physiotherapy may revive such folk lore. The men do not know if I am capable or interested in understanding their point of view, or PhX's point of view. Folk lore is one-dimensional, real life is multivocal and multidimensional – and such a story probably adumbrates more that meets the eye – particularly in a rural community. There are several instances of light laughter, but no one expresses actual repugnance for this particular therapist – the undertone is more reminiscent of sadness. To my knowledge, PhX was a close friend of some of them, and pursuing this topic was difficult and unnecessary. Gender and age (younger female researcher and male participants) may have induced some constraints.

Below, the topic of age and gender, pleasure and unease in therapy is discussed.

Tobba – (...) can you imagine, that some of these young female physiotherapist, below 40, there might be situations that are unpleasant for them

Alan – unpleasant for them or for us? (*laughter*)

Tobba – that was two questions, I've been told by female students, that if there's a man coming and he just wants to be caressed, it induces uneasiness in them

Alec – they become professional, and then they can cope with it, it's a job

Tobba – yes

Alan – I would not reject the idea, such a situation might emerge, but between younger people than here [in this group], especially today

Tobba – yes, they are young

Alan – it's so focused

Tobba – it's the young girls that feel uneasy, they may be single, and they haven't made their own boundaries for leading a life

Alan – I think they can, I do

Asgeir – I think, it may create an ambience that look alike something else we know, undressed, hot, and you can get association to non-medical matters, so to speak

Alan – yes, by the young, I see that

Tobba – it depends on age?

? yes, yes

Tobba – because if it were a lady your age...

? – no, that I wouldn't have given a second thought, (*laughter*) she'd to be considerably younger!

In the extract above, our talk about women's gender display and age is easily categorised along the Goffmanian gendered strands (for women). It was suggested that the young women might feel uncomfortable, particularly given the current sexualisation of the public sphere – the celebrated gender display – which was acknowledged by Anthony, Alec and Alan. When I teasingly suggest that a woman of their age could be their therapist, they laughingly respond that she would not make gender (as sexual beings) relevant – it would remain invisible or these expressions would be declined. And if it was brought up, they would act to put it down again. The woman would have to be significantly younger – and give a fluorescent gender expression – to make any connotation of sensuality and sexuality. By laughingly recognising this gender/age play, they remind me that they know the game. In our debriefing conversation after the session, Asgeir asked me if I had noticed that the men were flirting with me during the session. This was a surprising question, I had not given this a thought, our conversation seemed “natural” to me. This is exactly Goffman's argument and a key feature of gender as a social institution; men can always make gender and gendered displays relevant – drawing on the heterosexual backdrop or Goffmanian parent-child complex. It's natural.

There is another interesting comment in the extract above. “It is a job”, and the preceding “then they can cope with it”. The men in the D- and C-groups made related comments. You encounter all kind of people in all kinds of job, you have to learn to cope with it, be professional. The B-gentlemen did not touch upon the issue in their discussions. The A and B ladies, however, discussed the problem of the female therapist having to cope with a demanding male patient, and the problem a male therapist which had itchy fingers with his female patients. The women in the C and D groups did not touch upon these issues. The undercurrent plays on institutionalised expectations of gendered conduct and demeanour – one must expect to deal with problematic proximity and intimacy, because gendered interaction does embed these challenges. A key feature of social institutions is their repetitive practices – as suggested above.

Exceptional experiences

The group of A-men contributed two outstanding experiences to my material; a story about a German physiotherapist who climbed onto the back of her patient, and experiences with Thai massage.

Alan – it's heavy work, and lots of places where (the women) enter, and then it's uncovered, it's a failure, we have to acknowledge the difference between us, physically, and physiotherapy, that no easy work either, if it is to be done properly
Tobba – yes (some *laughter* in the background), the women told of the same, the use of hands, they make a difference of male and female, is that what's on your mind?
Alan – yes
Tobba – they are less firm?
Alan – yes, but once, I met a woman at a Hospital, educated in Germany, she was the best of her kind, and that is important, educational origin
Tobba – I think you're right
Alan – yes, yes, she was very clever, and strong like a bear, she went to it in a drastic manner, she climbed my back, kneaded shoulders and everything, that was efficient (*laughter* in the background), but a lot of them, they are only tickling you, might as well drop it
Asgeir – you think that educational origin
Alan – and strength
(...)
Asgeir – but if a man had done the same, would you disapprove
Alan – no, I wouldn't disapprove, but it was unexpected
(...)
Alec – but how about Thai massage, from a male
Tobba – total work over
Alan – it hadn't been that tempting (*laughter*)

This German therapist had climbed onto Alan's back without giving any reason or explanation to Alan. Earlier on Alan had received Thai massage on a vacation trip to Thailand. Both the Thai massage and the German therapy were wonderful, he told us. No one in the group were familiar with this German technique where the therapist sits astride the patient and works on his muscles. On the other hand, all of us have heard about how pleasurable Thai massage is supposed to be, and noted the sensual and sexual connotations constructed by the media about sex tourism in Thailand. However, these experiences made gender fluorescent and a job to be dealt with, as Alan had suggested earlier in the discussion. The German and Thai episodes called attention to a stereotypical heterosexual backdrop where men take pleasure in women's service. Asgeir and Alec recurrently ask Alan if he would have enjoyed the therapy as much if the therapists had been male. Alan denied the impact of gender several times, but at last, the group managed to make him say that it would not have been the same with a male Thai masseur. Alan's concerns are not discerned. He

might concur to a non-exploitation of Thai women (newspapers often accuses tourist of exploitation), but still hold on to his privilege of enjoying the sessions at a descent massage centre. However, Alan's concerns may be interpreted as a caution to make matters too simple. Interaction and experiences are multidimensional – always.

Exceptional experiences were shared among the D-ladies as well. Daphne shared one of her terrible experiences with the group, which made gender particularly relevant as an analytical approach.

Daphne – I have an experience from a Hospital, and a young male up-and-coming physiotherapist, and I felt I had to do things because he should succeed, not I, he whipped me up. “There you see, you're able to stand”, he said. He let me stand for half an hour to prove that I could stand. I felt fair, fat and forty,³³ whipped to stand, but then the senior therapist came along, and he [the junior] had to feel the weight of my arms and legs. I felt subjected to a particular unpleasant situation, and gender was a part of it

Tobba – he did what he did to perform clever, and you had to

Daphne – yes, yes, and in a condescending manner towards an old bag, right, that's how I felt, but the boss interfered

Tobba – did you see this therapist later on?

Daphne – no, he was taken away from me, by a senior female
(...)

Tobba – that boy was a particularly extreme exemplar

Daphne – I don't think he can be reckoned at all (*burst of laughter in the group*), I'm deadly serious you know

Daphne felt she was created as “fair, fat and forty” when she was strapped to a tilting bed. Following her lead, we can apply the Goffmanian ideal typical strands of gender. The young male was in his early twenties – a strand of celebrated gender display, Daphne in her early forties – the strand of multivocal gender display. Her self-presentation was dominated by gender, above health status and disability, while the young man probably related to gender as one of several signs given and given off. Following Daphne, the therapist declined her self-presentation as a woman with her own agenda and preferences regarding therapy, as knowledgeable about her body's strengths and vulnerabilities. At the time her disabilities left her few if any means of resisting, and she found herself in an extremely vulnerable situation. She felt she was on public display – in agony – to nurture his ego, she felt, which made her angry. Daphne is ascribed what the therapist has made of her: disabled, fair, fat and forty. As Goffman remarks, displays can be multivocal and different hierarchical statuses can be

³³ Førte, feit og ferdig

encoded in the same display – e.g. age, gender, and disability. Goffman’s notion of reciprocity in information exchange to create and sustain a definition of the situation is also demonstrated – by its absence. Accordingly, the one who has the physical means to control the other proceeds with his tasks. Daphne was alienated from interaction (Goffman 1967:113-36), but eventually got it her way by a proxy – a senior therapist.

Daphne’s body was constrained, and her presentation of self and her intentions were declined. Accordingly, her possibilities for enacting agency were limited. She did not accept being subjected to the therapist’s agenda, and kept looking for another person within range, who would see and understand her agony and fury, and who would act on her behalf – a proxy. Intentionality or agency is never muted, but when Daphne or one of her peers are incapable of moving themselves around, and they cannot or will not shout out loud, they become vulnerable when interaction never comes into play, or breaks down. Hermeneutics is the basic ground of life in a Gadamerian and Goffmanian understanding, and when denied social interaction there is no way left to communicate or to act. Daphne stresses that this experience was extreme, and that this particular incident is not a part of regular physiotherapy or physiotherapists practise. As such, she implies that with other therapist and in other situations interaction regularly come into play.

Quite ordinary, but pretty special

The point of departure in the extract below is a comment made by Desmond, designating the project information leaflet distributed as extremely boring – focusing on gender and interaction. This elicits laughter, and he goes on to explain that it is more to these encounters than implied in the leaflet.

Desmond – it’s an interesting question, but not only in relation to physiotherapy, as we have discussed, there are lots of everyday situations that would be different if gender or age were different, (...) but one dimension distinguish physiotherapy from other situations, you can’t choose it, you just have to relate to it, you might get a referral and have to comply, to us, veterans in the game, we chose a therapist we place confidence in, and evolve a relationship, as opposed to shorter treatment relations, we stick to the same therapist for years
Tobba – but do you think, is it the same as other social encounters, isn’t there a difference, it’s your body that’s the object for the encounter (...) people get pretty close

Desmond – and the time span matter as well, but there are everyday situations that challenges you, body and soul, go to the pharmacy and buy contraceptives, depending on who's behind the counter, an old bag, and it's ok, a young babe, and the interaction changes

Duncan – you turn red, and feel a bit ...

Desmond – yes, then you have to decide whether to enter, or return another day, but of course, your comment on the body, there's a point, the bodily issues of physiotherapy

Having a weekly physiotherapy appointment might seem like luxury to some people, but to others it is a “life sentence.” However, Desmond expands on being an ‘involuntary patient’, and explains the difference which makes a difference. When you have been in this game for decades, you know your way around, and choose your therapists with care. Others, who accidentally have to interact with a physiotherapist, are left to a chance encounter. Desmond argues that the interaction in physiotherapy resembles other social meetings and interactions, where age and gender might be of importance. As an example he uses buying contraceptives in a pharmacy.

Nevertheless, Desmond arrives at the conclusion that physiotherapy is more than an ordinary social encounter, given the fact that the interaction is concerned with a body – namely the patient's body, or in this situation, his body – which makes it pretty special, after all.³⁴ The intersections and interferences between social institutions and displays as gender and age are further complicated when disability is added. The disabled body somehow makes gender less prominent and the bearer a non-sexual being. If you have a congenital impairment, like David, you are denied the privilege of being young and lustful, of being a celebrated sexual being – an issue making him quite angry. The others experienced the vitality of youth and lust before their injury – acknowledging David's point. Using a wheelchair marks you as a disabled, not a man, a sexual being, a librarian or computer scientist – just an ‘invalid’, a concept still used, as David reminds us. Disability is a denigrated social status, and when intersecting with age and gender, disability emerges as the prime category to apply in many social encounters. This is regularly happening when the signs given off from the body and its props are beyond the persons' control, and difficult or impossible for the audience to ignore. Nobody asks David if he is married, has a live-in partner, a lover or children, he tells. Brown & Russel's study stresses that people with disability are sexual beings – implying that previous knowledge on physical disability and sexual health is meagre and incomplete. By

³⁴ The expression ‘Quite ordinary, but pretty special’ is borrowed from Malterud 1992a: Helt alminnelig – og ganske spesielt. My translation.

not recognising sexual well-being needs, carers may be failing many people with physical disabilities (Browne & Russell 2005).

The accounts given by Desmond and David demonstrate that talk about health related issues involves more than making statements pertaining some neutral field. They are talking to someone in a context and their accounts are claims made in relation to the world in general. However, there is a particular feature of interview situations which ought to be discussed according to Radley & Billig, when the issue of interests concerns the participants' health in one way or another. In a research group participants (with a medical condition) are speaking to people who might be experts in these matters, but more important, who are also health-privileged because they are doing their work as researchers (Radley & Billig 1996).

Implicitly a connection between health and employment is made. Here ideological issues are apparent, Radley & Billig state (ibid.:225). The "good patient" is an enactment of sociological ambivalence, where claims to recover 'normality' or claim to be unable to work must be asserted (Merton 1976;Parsons 1975). Above, Desmond and David are relating to the world in general, referring to common experiences that everybody recognises; the normal embarrassment of buying contraceptives, the normality of having a girlfriend, a live-in partner or family, the everyday character of seeing a physiotherapist. The need to legitimate one's position extends from those who consider themselves in robust health (researchers doing their work) to those who are severely ill or disabled, Radley & Billig contend. Desmond's initial comment on the information leaflet alludes to the same normality; seeing a physiotherapist is just a part of everyday rounds, no case for inquiry. In the references to commonplaces the speakers construct a 'normal everyday identity', in which the 'extraordinary' is made ordinary (Radley & Billig 1996:225).

Accountability

Following Goffman, there is a deep belief in our society that objects by their mere existence give off signs that inform us about the object, and impart claims and promises. Objects (or persons) are thought to structure their immediate environment, and leave an imprint, a portrait that is unintended but nevertheless informative. This is a kind of by-product, an overflow or spillover, a marking of the environment wherever the object (or person) has been. People give signs, and give off signs, during interaction. However, a straightforward analysis

of how the interactants interpret each-other is not available. In the extract below Alexandra is discouraged about lack of follow-up from her hospital, and she tries to figure out how this came to be.

Alexandra – I had this back surgery some years ago, and they sent me home after 6 days, told me to do 4 exercises twice a day, and no more follow-up, and these exercises I did, they didn't do any good, I couldn't walk, stand or sit or anything. Then after a few weeks I called my local Hospital to ask for treatment and pool exercises, but then the other Hospital had to confirm this. Then I called the first Hospital, three times I did, and cried, I cannot sit, I want to go to the therapy pool, "Okay then, you just go along" [mimicking a very patronizing and arrogant voice]

The hospital has several signs at hand to create 'Patient Alexandra', including her disorder, age, sex, unfamiliar accent, and verbal style – early warnings signs given off and informing the hospital spokesperson on the phone. Their construction of 'Patient Alexandra' differs from Alexandra's intended self presentation. She has tried to be compliant with the post-operative regime, but has not recovered. The spokesperson sounded arrogant and patronizing, and implied not to care about Alexandra's self-treatment programme in the pool. Alexandra feels the remarks to be offensive and painful, as a way of underlining the hospital staff's privileged position in relation to her, as a parent would put an unruly child in its place. Parsons institutionalised superiority and Goffman's parent-child complex is illustrated (Goffman 1979;Parsons 1975). The women in the research group are quick to laugh when Alexandra says she believes she is treated differently because she is a foreigner, and when she tells them that arguing with the hospital only results in flat denials. Some of the other women reminded us that if you are ill, you do not have means or strength to protect your interests, or lodge a formal complaint. However, if you dare to say what you think, it is interpreted as a sign of good health, and they discharge you, Alexandra believes. Annabel suggests this is a question of denying women, and has nothing to do with disorder, conduct or style or being a foreigner.

Alexandra's experiences illuminate some of the difficulties in passing as a credible (female) patient.³⁵ Gender styles qualify, Goffman argues, and so does disorder (Goffman 1979:6). You either pass, or you do not pass. The discussion ends in laughter, and underlines the problematic politics of passing as a (female) patient. You risk being labelled perfectly healthy if your compliance is low or your performance seems "healthy" – or "womanish" as Annabel

³⁵ The concept passing is coined by Goffman, and used by Werner and Malterud in their studies. See Goffman 1964; Malterud 2001c; Werner 2005; Werner, Isaksen, & Malterud 2004; Werner & Malterud 2003

suggests. However, these ladies are engaging themselves in negotiations with diverse health care agencies, at the risk of being refused or discharged.

As touched upon in the section above, thinking about health and illness is always ideological and dilemmatic. Radley & Billig argue that the accounts people give are more than description of physical conditions, they articulate a person's place in the world, in which the person has to be held accountable to others (Radley & Billig 1996:221). The sick are encouraged by the healthy to redefine their misfortune. Then they are accorded "strength in character", and are worthy to be looked after, as if too much weakness should be insupportable (ibid.).

Age and gender

Martin forwards an argument on internalisation of institutions by the human actors who constitute them (Martin 2004:1255). If social institutions are internalised, then the body and embodiment are central in this dynamic. No institution stands alone and gender is everywhere, as is age, and institutions intersect. Framing gender (and age) as social institution is beneficial in drawing attention to its multiple features – ideology, practices, constraints, resources, conflicts and power – and affirming its complexity and multifacetedness. No one can study all aspects, but rather provide a window and tie into a larger picture. Below, a discussion of the intersections of age and gender is taking place in two different groups:

Tobba – what do you think, as Asgeir mentioned a few minutes ago, that age and age differences might be of importance, or [would it only matter] if you were in your 30s?
(...)

Anthony – well, a firm grip on the painful spots, and if it was a good looking woman it might have changed the ambience, but it had not been negative (*laughter*) but that male Finn was very nice, so I do not think I would have thought of it [gender] at all, if it (the grip) is firm
(...)

Asgeir – one can ask if this is so important, we might be charmed, on the other hand, when the spread comes, you don't feel on the same wavelength as a 25 years old, she could have been my daughter

Tobba – what do you think

Andrew – yes, it's something there

Tobba – but we are able to flirt all our life, but maybe it changes, you are the experts on these matters, sine you have lived longer than me

Alec – maybe age is of minor importance

(Laughter)

Albert – it can turn backwards – you might feel old as the hills – “Are you able to get to bed on your own?”

(Laughter)

Tobba – what do you think, those who were elder than us suggested age was an important factor, if you had met a therapist your own age, 18-19, football playing is a game, flirting is a game, something else is happening if the age-grade is close

Conrad – generally speaking, if it is a physiotherapist or a doctor, I’m not comfortable in the situation, to flirt, I’ve had these groin injuries, and if I met a girl my age it would have been very uncomfortable, I prefer a 50 year old man, that’s the best, then you don’t have to think about that

? – in cases like that, I understand it might be unpleasant for the therapist as well, if it’s a female

These two extracts illustrate the intersection of age and gender in different ways. *First*, if a young female therapist treats older male patients, it might make a positive difference, and create a pleasurable ambience, according to Anthony. On the one hand, when women at men’s service are appreciated by courtesies given and received, the gender hierarchy is the backdrop, at least from the dominant male point of view. On the other hand, women at men’s service might respond to age expressions, but decline to respond to gender signs. On this understanding, the females are dominant and the men may be belittled due to their age, caressed by the women – as “mothering.” The older males may be charmed by young female attendants, but experience the weight of their own age above gender. *Second*, Asgeir suggests that middle-aged spread makes men feel less attractive, particularly if the therapist is as old as one’s own children, an understanding Andrew recognises. When the carer is too considerate or helpful, it can make you feel old as the hills, to quote Albert. *Third*, Conrad, a young athlete, wanted a therapist of his father’s or grandfather’s age to treat his groin injury, not one of his own. Whether young or well on in years, a large age difference makes gender less prominent as a sign vehicle. Anthony’s utterance on firm grips as more important than gender, may be due to age differences. The *heterosexual* backdrop declines in importance as age becomes the predominant status. In same-age contexts, the young athlete is deemed to act upon visible gender all the time and might appreciate a non-sexual homosocial relation with his therapist, particularly when dealing with groin injuries or the like.

Beatrice – I would say, the male in the Mediterranean, if he hadn’t been so young, but a good looking man my age, then things had changed, that one was professional, that was ok

Beth – did it have anything to do with his appearance?

Beatrice – no I don’t think so, he was at the same age as my kids, but if he had been an adult man, I would have experienced it quite differently

Britney – or been embarrassed on the thought of creating a misunderstanding, otherwise, they are asexual all of them, that’s my view, but I don’t know if (laughter), no, I do not care

Beatrice – but if a 17-18 year old (girl) were given the same treatment as I got, she had been shocked, but to him, whether I was a woman or a man, he just worked on

Alan – it might correlate to body part, especially if you are younger, but today, I couldn’t care less

Albert – no, no

Alan – but when younger, I imagine it would matter

Duncan – I’ve been shaved and prepared to surgeries twice [by female nurses], in my early 20s, and next time late 30s. That was a difference that made a difference, your thoughts are different, you take any help you can get. Last time, I was married, had kids. It doesn’t matter, get it away, I think, like you, more clinical, they help me, but I confess, I did not think like that the first time, I felt different

Britney’s ambivalent argument that sexuality and age might not be interrelated is contrasted by Beatrice. She argues that the treatment she received could have been devastating to a girl in her late teens. She admits that if she had been 30 her therapeutic relationship would have been very different. She laughs, and reflects upon what would have happened if she had taken her bra off, or kept it on, or dressed differently. There is no conclusion to this dilemma, because she had to remove the bra anyway. Alan, Albert and Duncan add to the same argument; gender, as celebration of the sexual body and social alignment, fades into the background as age and health concerns loom. These extracts illuminate Radley & Billig’s argument on thinking as dilemmatic (Radley & Billig 1996). There is no simple answer, because age and gender are situational properties and accomplishments, it is an interpretive scheme and embodied knowledge. When accounts are given they relate to the groups, as well as to the situation they are representing. Accordingly, agency is also dilemmatic.

Disability and gender

In the physiotherapy clinic, the patient’s *body* is the subject matter in the encounter between a therapist and a patient. My proposal is that the three ideal typical strands of gender/age introduced in the section on gender display above are equally applicable to disability.

Depending on the context, a disability or a prop such as a wheelchair is both fluorescent (celebrated), in limbo (multivocal) or invisible (declined) – and it intersects with age and gender.

Tobba – but how is this to you, they had learned something about themselves before the injuries, but you had to learn as you grew up

David – well (...) it came to a certain point where I got turned on by the one who attended to me, that wasn't any cool experience, I didn't want her to see that part of me

Tobba – no, because that belongs somewhere else

David – yes, and the same goes for girlfriends, it's too much to tell, and if things are getting at somebody first, that's not very cool, and you get in trouble trying to explain, and feel much belittled, and this is the same towards carers or friends, I don't want them to see this part of me, I want to tell about it first

Tobba – make your own presentation; decide for yourself, who you want to be in this setting

David – hm, yes

(...)

Tobba – I think I understand your point, but, if we turn it upside down, (...) it's not easy to walk out on you, ignore you, because you are talkative and easy to converse, then you encounter the employees in another manner, than if you're having a blue day, and maybe they experience you as a dangerous man

David – yes, yes

Tobba – I don't know, have you ever given that a thought?

David – yes, of course, but there is a major difference between us, you can change occupation, I can't change my disorder

Tobba – that's true

Duncan – there's something

Tobba – or I can tell my peers that I can't take it anymore, and ask them to see you

Desmond – hey you, you old bag, can you please go to him?

Laughter

Tobba – yes, his flirting is killing me

Laughter

The extract above clarifies Goffman's concepts of giving and giving off signs in a social encounter. David's body sometimes gives off signs that carry particular information, and uncover personal and vulnerable sides in any social context. David's body, as everybody's body, can be sexually aroused if touched. However, when this touch is applied in a professional care setting, the carers may recognise his sexual arousal as an invitation, in David's opinion. Interpretation of signs and negotiation of boundaries are difficult when signs are unfamiliar or unexpected (Browne & Russell 2005). This illustrates Martin's point that gender is everywhere, as well as its intersection with age, and hence sexuality. However, disability may be construed as an institution as well, as persistent, repetitive embodied practices, and a set of expectations and interpretive schemes. Before these issues are dealt with, the context of daily life for youths growing up with a disability must be addressed.

Whether growing up with a congenital disorder or having acquired a disorder in late adolescence or young adulthood, must be taken into consideration (Grue 1998;Grue 1999;Grue 2004;Solvang 1994). It makes a difference if you have been able to participate in “normal social life”, or have grown up partly in hospitals, and seldom been able to socially interact without planning and assistance. Growing up with a disability often confines the child or youngster to the family sphere and the professional assistants – due to practical or medical constraints and despite efforts to make it different. As a result, all aspects of life are played out in few close relations. Both aggression and sexuality have to be dealt with, as must love and grief, within the family/provider sphere. As Donald said, “I ran after girls for years and years before the injury”. Knowing this, I ask David how he learned to be a young man, and a man with a disability. David’s answer is a story about the need for intimate relations. He experienced unwanted sexual arousal in the presence of his professional assistants, as well as difficulties with potential girlfriends because of his disorder. This devastating revelation of a personal side to his social life gives reason for his succinct comment about being treated like contaminated waste (cf. chapter six on touch). However delicate these negotiations are, Brown & Russell report that sexual relationships between professional carers and people with physical disabilities were more common than they expected (Browne & Russell 2005). David, as everybody else, wants to present himself to a social gathering. In his experience, his body and props gives off signs that revive prejudice against people with disabilities or particular disorders. There is a lot to tell about living a life with a spinal cord disorder, David says, and he wants to communicate this in controlled portions to carefully selected persons.

Disability and sexuality is an ambiguous issue, immersed in prejudices and folk lore. Donald and David briefly talked about being out on the town. Occasionally they experienced late hour’s addresses and questions by animated strangers (girls/women) about their sexual life. The only way to stop this kind of unwelcome attention was to invite them home for practice sessions, they told us. According to David, whether lay or professional, few people are knowledgeable about the issue of sexuality and disability. This engenders misunderstandings and embarrassing situations. If a body marked with disability displays signs of sexual arousal, this is often surprising to onlookers. More often these signs are interpreted as unwelcome sexual invitations or harassment – especially if provider and receiver are similar in age. David has to pre-empt suspicions and misunderstandings, as well as control his body as far as possible – more than the able-bodied, but perhaps with fewer means at hand. His story

however, alludes to “normality”; we all take care when it comes to safeguarding personal boundaries, sexual access or courting.

David’s stories about maltreatment and wounding experiences reveal his expectations of professionals. He is a funny, good looking and talkative guy and in the extract above I tried (not very elegantly, regrettably) to turn the tables on him. To illustrate my point, I try to invite him to reflect over the possibility that the nurses, therapists and others find his demands or style difficult to handle. David accepts my attempt to turn the tables, but turns them back again. As he correctly states, I can re-educate myself or change working environments. He has to live with his disability and what follows from it. I subsequently tell about a well-known method of peer team work – making interchanges on the backstage. Desmond relieves the tension by introducing the possibility of sending the old bag to the young flirting male patient, an exit I welcome.

The diverse interrelationships between patients and staff are well known to “insiders” like us. On the one hand, the D-gentlemen have launched the idea of applying the ‘personal ad test’, which combined with interchanging patients/therapists may increase the outcome for both parties. On the other hand, the same checking out might be detrimental, unless there is a real possibility for exchange and interchange. An attitude towards each others as “disposable” creates fewer openings for reaching the other, and establishing a creative and sustainable relation – independent of the impressions made at first sight. Here Gadamer’s hermeneutics as a way of being is a pertinent reminder. Where there is conversation, there can be dialogical understanding. And further with Goffman, a situational definition can be established, and the encounter can come into play. The moral implication is troublesome too; if you know there’s a second option, you might not approach the other person in a curious and creative matter, or try to be an attentive listener. This is particularly troublesome if the professionals are relating to their patients as disposable objects. Desmond illustrates the ever present potentials: ‘The first times, they are this and that, but later on, we work it out.’ There has to be a careful application of the ‘personal ad test’, to pre-empt destroying a good relationship before it had a chance to come into play.

Interpretation is never done; there is always another question to be asked, or suggestion to be made. Is David' story about a flirting and talkative personal style, or is he posing demands beyond any reasonable limits? Or should the finger point to the providers? Are their doings mere enactments of prejudices? If he had had a meniscus rupture (a common football player injury), and his style the same, would the carers feel flattered or annoyed? Do his disability and all its implications construct him as a difficult patient instead of an attractive athletic male diver or hockey-player? Able-bodied athletes are fit; what they need are some minor mechanical adjustments, which may be David's entitlements at the hospital as well. The athletes' bodies tell of good fortune, whereas David's props give away constraining conditions. Able-bodied athletes are in the best of health all of the time (relatively speaking), and their need for post-operative advice and treatment may easily be played out within a flirting frame. Why aren't the carers playing the same game with David? Is it not possible to escape a disability, or to have a break? Recalling working at an orthopaedic hospital department with male able-bodied athletes with, relatively speaking, minor sports related injuries, I argue that disability leave a huge imprint on David's other displays or accomplishments – and he is not permitted to present himself. He is alienated from a particular playful mode of interaction.

Communicating ailments

As discussed in chapter five, the dialogical interaction with a doctor or physiotherapist is of utmost importance. The extract below is from the A-ladies' discussions on ailments, diagnosis and status hierarchies, and their experiences related to conversations with doctors on these topics.

Amy– fibromyalgia, that's a word of abuse to many doctors, that's no disorder

Augusta – even some rheumatologist thinks that's a curse

(...)

Annabel – my previous GP³⁶ said there no such thing, but he sent me to the Rheumatics Hospital in City (...) an after an hour she said there were no doubt, it was fibromyalgia [but her GP still did not believe her] he hadn't got any report he said

(...) and I felt, there is no such thing

(...)

Annabel – can there be something about [gender], this is a women's disease?

Amy – I've heard of men as well

(...)

Amy – if there had been as many men as women

³⁶ General Practitioner

Augusta – then it would have more prestige
 ? – if rheumatics in general had been [more prestigious], then they had allocated more money to research (...)
 Annabel – it’s just the same with women’s heart diseases
 Amy– yes, they are second class
 (...)
 Annabel – and after the [heart] surgery, my GP said, “You can have myalgia even if you have heart problems”. He still considered himself rightly [her GP did not believe she had a heart condition either]
Lots of laughter
 ? – would not give in
 ? – that’s typical
 ? – typical
 ? – why shall they not take us serious, just as well as any man?
 Annabel – (...) we are going around in agony and pain, and they do not believe us, that’s painful too

The women discuss how hard they have worked to make their complaints understandable to their GPs, and to make the GPs recognise the women’s experiences as a relevant body of knowledge in medical practice. On several occasions during this group discussion Annabel asks ‘is this happening to us because we are women?’ The group acknowledges her point, and discusses low status and low research priority given to e.g. fibromyalgia and female heart conditions. These women tell their GPs a lot about their lives and health problems, but their contribution to the interpretation of their problem is not recognized. As a result, they risk losing confidence in their own body (Malterud 2001;Råheim 2001;Råheim 2004;Råheim 2006). Gadamer and Svenaeus states health as a sense of homeliness, to be at ease with oneself in such a manner that health and body are ‘forgotten’ (Gadamer 1996;Svenaeus 2000a;Svenaeus 2000d;Svenaeus 2001;Svenaeus 2003). Losing confidence in one-self will add unhomeliness to ailments and uneasiness, and purport an uncanny experience. To regain health and restore well-being, the health care provider may offer assistance. By way of dialogue or *phronesis*, embodied knowledge can be acknowledged and employed. This kind of assistance is not traceable in the accounts above.

Merton suggested, that ‘good doctors’ better be described by the concept of sociological ambivalence. Learning to be a doctor is to blend potentially incompatible norms into a functionally consistent whole (Merton 1976:65-72). Radley & Billig extends Merton’s argument to the good patient. The patient must appear to be more than a patient; a display of healthiness, or normality, is also required, for the ill person to appear worthy of receiving the entitlements (Radley & Billig 1996:222). If the ill person is only an ill person they will fail to

warrant their special claims, as they will do if they appear to be healthy. In this respect the ill person is both more and less than a physically functioning body (ibid.). In this ambivalent sociological perspective, the women above try to appear as ‘good patients’ before the ‘good doctor’ – by inviting the doctor to participate in a conversation, and by applying diverse passing strategies, as discussed in the section on accountability above.

Due to personal experiences, most of the women favour female physicians in spite of positive experiences with a few males. Annabel explicitly credits her male physiotherapist, who supported her interpretation of her ailments, and encouraged her to confront her doctor. The national evaluation of the regular general practitioner (RGP) reform confirms this as a tendency; there is a drift of patients from male to female RGP (Sandvik 2005). Gendered expectations are internalised and embodied, and enacted in any encounter. Being a good doctor or a good patient are enactments, where gendered expectations come into play. Both the women’s experiences and the national evaluation suggest that a female doctor is met with other expectations than her male peer, and henceforth these encounters evolve differently. Believing is seeing, and without a critical interpretation biological sex may come to represent a particular capacity for being a good doctor, physiotherapist or carer. The case is rather a matter of learning how to be a good doctor or physiotherapist. Goffman summarises:

What the human nature of females and males really consists of ... is a capacity to learn to provide and to read depictions of masculinity and femininity and a willingness to adhere to a schedule for presenting these pictures, and this capacity they have as human beings, not as females or males (Goffman 1979:8)

Physiotherapy is deeply rooted in and indebted to medical knowledge. This means that biases follow. Classic examples range from lack of differentiation between females and males in diagnostics and treatment, with subsequent poorer results for women if the male standard is applied and vice versa, to lack of frames to understand complaints that do not give off so called objective signs – and hence are labelled medically unexplained disorders.³⁷ The title of one of Werner & Malterud’s articles on the matter is expressive: ‘It is hard work behaving as a credible patient’ (Werner & Malterud 2003). The analysis Werner (2005) presents in her doctoral thesis shows that for women with chronic muscular pain, the struggle for credibility and dignity in the medical consultation and in everyday life can affect their efforts to

³⁷ See Malterud 2001c; NOU 1999:13 1999; Schei, Botten, & Sundby 1993; Werner & Malterud 2003 for exemplars

reconcile themselves with a life of chronic illness. Negative reactions from the doctor or others, can make the women disregard or deny their pain and needs. This is cognate to Råheim's studies (Råheim, 2001, 2004, 2006). However, if the doctor recognises their pains and ailments, guarding dignity can be replaced with reconciliation and adjustment to illness, Werner remarks. Lilleaas's studies of women living with chronic pain contribute to the same picture (Lilleaas 1995;Lilleaas 2003). Most of the women were disappointed with multiple encounters with various physicians, health institutions and professions. They felt they were under suspicion and deliberately misunderstood. They seldom had a chance to tell their story to an attentive listener. The same type of story was told by the A-ladies. Annabel's last comment pinpoints the argument: Being rendered suspect by your doctor adds to the pain, and decreases the space for reconciliation or adjustment strategies. The chapter on body politics, chapter ten, enlarges on this issue.

Laughter is sparse in the last extract from the A-ladies. However, the group laughs heartily at Annabel's stubborn doctor – who never admits that he was blinded by his own construction of 'womanish complaints' and missed her heart condition as well as her fibromyalgia. The absurdity of rejecting a diagnosis ascribed by a rheumatologist and stick to general myalgia and asthma even though Annabel had survived a heart attack (and subsequent heart surgery), elicits lots of laughter. This laughter can be interpreted both as a support for Annabel's caricature of this peculiar doctor, of her pain, fear and agony, and as making fun of know-all men and male-biased medical knowledge. Laughing is also acting, creating a new understanding of the situation – as reconciliation and a contribution to crafting a body politics.

Impairments or diagnoses are gendered – both as a result of gendered distribution, the history of medical knowledge production, and different conditions for boys and girls, women and men. The hierarchy of diagnoses and medical specialities are also sensitive to gender. A conspicuous phenomenon is that impairments that make people "bleed or die" have a higher status than those resulting from bodily wear and tear. According to Album's studies, diseases and medical specialties differ with regard to social prestige (Album 1991;Album & Westin 2008;Norredam & Album 2007). Among the diseases, myocardial infarction, leukaemia and brain tumour are ranked highest, and fibromyalgia, hepatocirrhosis and depressive neurosis

come bottom. The difference between the ratings of the doctors, medical students and representatives of other health professions (including a few physiotherapists) was minor. In short, the experiences of the A-ladies reflect the same ranking – collected through hard-earned bodily experiences.

Status spillover

Football is a big issue in Norway, and everybody, but especially boys, have to take a stand on it. The best players are heroes to the young, and have devoted fans of all ages. They enjoy special privileges in their respective cities, among them admission to physiotherapy clinics. Asgeir suggests that athletes are attractive patients as well as partners. Charlie, Carl and Conrad do not see themselves as attractive patients. The reason given draw upon a heterosexual backdrop as well as a significant age difference – i.e. an elder male therapist is not likely to feel attracted to a young male athlete. The C-gentlemen are more familiar with male (middle aged) therapists, though some of them have had female therapists as well. From other participants' point of view, the status 'athlete' spills over, and makes them attractive patients, as discussed by the D-ladies below.

Conceiving injuries and ailments implies conceiving gender, i.e. the cultural layers of biological sex categories – as in Album's studies of disorder and medical specialities (Album 1991; Album & Westin 2008). When an injury, e.g. ankle sprain, ligament rupture, tendonitis, or muscle stretch, is conceived as a typical sports injury, it informs the understanding of gender and the understanding of the injury. The extract below explores the connection or spillover between social status, gender and injuries.

Diana – a sports related injury, then you are treated differently

Arnchild – then it's more delimited?

Tobba – it would have been funny if any of you had a sports related injury to compare and contrast

Daisy/Diana – I have

(...)

Diana – I went to this sports therapist, my cruciate ligament was torn, but he gave me the impression that I was only a mother who had fallen skiing

Tobba – a mother? skiing?

Diana – yes, because most of our patients are athletes, he told me

Tobba – I see

Diana – yes, that's the impression he gave, [but] the treatment was good, and he was professional, so I recovered

Tobba – so, if you're an athlete, and then a mother, the athlete covers the mother?

Lots of laughter

Diana – I felt the mother was more visible

Roaring laughter

Tobba – clumsy mother, injured when skiing

Diana – I got a young male, I was 35, and I had fallen, skiing

Laughter

The backdrop for this conversation consists of hearsay, media reports and personal experience; athletes have privileged access to and receive better treatment from physiotherapy clinics. A cruciate ligament rupture in the knee of a skiing mother or a female handball player may be produced by identical biomechanical strain, but recovery and rehabilitation are conceived and created as different – you are either a mother or a handball player. The story told by Diana on how her injury was considered the result of clumsy skiing, rather than something that could happen to any sportsperson was revealing. She was still young at the time, but the therapist was younger and could not decline her mother status. This adds up being a mother is a full-time occupation (Hochschild & Machung 2003), and no one lets you off duty, not even the therapist. The group was quick to laugh at this phenomenon.

A woman in her early thirties participating in corporate sports activities would (theoretically) be allowed to “escape” her marital and family status if she was injured in a match. Similarly, a man in his thirties, after an injury in a sit-ski competition, might (theoretically) be allowed to “escape” his disability status, and play up his “normality”. As Goffman has shown, in any social situation, we are preoccupied with impression management, information collection and interpretation of the people and context at hand. In some small situations, status characteristics such as mother, athlete and disabled fade into the background, but continue to shape our understanding. We might be impressed by the sit-skier's accomplishments, because he *sits*, not because he is a fabulous skier. Likewise, we might be impressed by the woman's everyday orchestrating of and results in corporate athletic championships, because she is a *mother* and *employee*, not an athlete. My argument is not to underscore either the sit-skier's or the corporate athlete's (or the sports physiotherapist's) accomplishments, but rather call attention to social statuses, and the imprints they leave, and expectations they elicit.

Studies of the intersection of motherhood and workplace outcomes, reveal that the disadvantaging effects are derived from the devalued social status attached to the task of

being a primary caregiver (Ridgeway & Correll 2004). When motherhood becomes a salient descriptor, as in the case with Diana above, Ridgeway & Correll argue, the evaluation will be downwardly biased. They argue that biases evoked by motherhood will be more strongly discriminatory, because of the cultural definition of the good mother. When expectations are lowered because of motherhood, the recognition of a good skier having a regular accident becomes difficult. Ridgeway & Correll studies reveal how social institutions and statuses intersect, to women's disadvantages. However, as they conclude, identifying the "maternal wall" is the first move towards dismantling it (ibid: 697). Kögler contends that it is not the mere existence of a stable background of social institutions, but rather the capability to make use and draw on background resources in a productive manner that makes autonomous agency possible. Hermeneutics can then fruitfully relate its conception of human agency to a theory of social institutions understood as both enabling backgrounds of intentionality and institutional structures of power (Kögler 2006:215)

Closing remarks

This chapter has construed gender as i) a social institution; i.e. as naturalised interpretive schemes, as enduring social structures and as principles for resource allocation, and ii) as agency and accomplishment; i.e. as action and ways or modes of acting based on the understanding of the situation at hand. Gender is further construed as a site of conflict and multiplicity, and as other social institutions it is reproduced and changed due to collective agency. This complex is summarised as 'doing gender'. Even though patients take great care to meet local standards of propriety, age, impairments and disability intersect with gender, which may create disjuncture or threats to the interaction. Gender spills over, and imprints understanding and treatment of the issue at hand. Furthermore, gender evokes sexuality, which may disrupt the social situation, or add an appreciated supplement. Most of the participants preferred same sex relations to their therapist, related to an implicit heterosexual paradigm.

The next chapter turns to pain, as a paradigmatic exemplar of how spoken and bodily communication, self presentation and gender intersect in physiotherapy.

9. Pain; body idioms and displays

This chapter is not about pain as such, but deals with pain as a salient and recurrent issue in the group discussions. Many of the participants were emphatic about pain, and particularly concerned about how to communicate the experience of pain to another fellow human being. The participants in this study share experiences of being in severe pain while trying to keep up with the rounds of daily living. The seemingly incommensurable experiences and strategies concerning pain in young elite athletes and in adults living with a chronic illness are more cognate than estranged when analysed.

Following Radley & Billig, the body is both a medium through which individuals can portray their health (or illness) and a topic of these portrayals. This is not a pointing to signs of disease or their absence. It is an enactment which displays and thereby exemplifies conceptions of health and illness (Radley & Billig 1996:236). Goffman's description of gender displays is equally relevant to displays of health and illness:

Displays don't communicate in the narrow sense of the term; they don't enunciate something through a language of symbols openly established and used solely for that purpose. They provide evidence of the actor's alignment in the situation. And displays are important insofar as alignments are (Goffman 1979:1).

Radley & Billig contend that health displays are the portrayal of one's health or illness, a dramatic representation of a condition that can be given a diagnose or name, but still must be shown forth. In that sense, it might be taken as a fragment of a larger whole, a dramatic performance by a player in the world of health. Such a display alludes to a state of being, as a kind of speaking in everyday life; being healthy, being ill. Warrants and justifications need not be wholly concerned with what is said, but with how it is being said in that particular exchange. They are expressive and constitutive ways of being that are invoked in the telling about health and illness (Radley & Billig 1996:236).

Goffman's concept *display* was coined in the late 70ies. Fifteen years earlier he coined the concept *body idiom*, denoting engagement in communication not necessarily connected with particular verbal communication. These comprise bodily appearance and personal acts; dress, bearing, movement and position, sound level, physical gesture such as waving or saluting, facial decorations and broad emotional expressions. In every society these communication

possibilities are institutionalised, he contends (Goffman 1963a:33). Body idiom is a conventional discourse, and a normative one, Goffman goes on. One has an obligation to convey certain information when in the presence of others, and a corresponding obligation to not to convey certain information. Others present have the same obligation. An important observation made by Goffman, is that there seem to be an agreement not only about the meaning of the behaviours that are seen, but also the behaviours that ought to be shown (ibid.:35). This pinpoints the challenge facing persons in pain; they have to negotiate conventional and normative discourses on pain and show the “right” situational body idioms. Although persons can stop talking, they cannot stop communicating through body idiom; they must express the ‘right or the wrong thing’. Pain is that which is neither this nor that, and yet it is both – which represents a serious threat to communication.

Pain rituals, ranging from torture to self-mutilation and piercing are historical and cultural situated practices, and as such studies of pain might be conceived as cultural studies (Kraft 2005). In this perspective, the way we describe pain as a generic phenomenon, or try to make our own pain intelligible to others, differ across time and place. In her study of torture, Scarry shows how pain is an individualising experience, turning your attention inwards as the title of her book suggest: *The body in pain; the making and unmaking of the world* (Scarry 1985). Perceptions or experiences gained through sight, hearing, feeling, smell or taste regularly call us outwards, towards our social and material context. By contrast, when the perceptions or experiences exceed a certain limit they are conceived of as pain, which calls us inwards. The person in pain will shift her attention from the surrounding context to her own experiences, to a lesser or greater degree. Persons even physically close may be conceived of as beyond perceptual and interactional range. The more the experience of pain engrosses, the more difficult the person may find it to communicate her pain. To save her face in a Goffmanian understanding, she must give signs and impressions that displays the state of pain and suffering through acknowledged body idioms (if available), or display whatever appropriate to provide evidence of her alignment in the situation, or concentrate on passing as “pain free.”

Body idiom – pain

Whenever encountering a physiotherapist or a doctor, or a researcher inquiring into health related issues, people give accounts of their state of being as means of aligning oneself with the situation at hand, and the situation at large. The accounts given reveal something about the person speaking, but more important, is what the accounts reveal about what is presumed to be anticipated or expected of a person of their kind (e.g. disabled, athlete, old, woman). In other words, when accounts are given people present themselves as “normal” in relation to social expectations and institutions, and give reason for why they can or cannot comply or keep up with social expectations. The male athletes did not make an explicit point of being in pain, but approached pain through a discussion of presumed gendered conduct – or a gendered display of pain.

Tobba – I had this idea, to pay attention to the body, to tell or do something about it, I wonder, is there any difference between being a boy or a girl? Because boys and men are supposed to endure more than ...

Chris – that’s the gender roles, boys are to be tougher, endure more

Tobba – girls are permitted to tell if they experience some

Chris – it’s more legitimate I think, but there are some at my team, they are much more, suddenly they lie there screaming, it’s gone in a minute, and then its physiotherapy, there are lots of people that wouldn’t have done it like that (...)

Carl – I don’t think men endure any more than women, I don’t think the limit of pain is much higher, e.g. low back pain, then girls postpone physiotherapy longer than boys, I think

Chris – I think men push their limits more, get at it, they give more

Tobba – as an idea, if we could measure pain it was equivalent, but what we are raised to endure is different, and within this sport, then you have to endure a hard blow [trøkk], to be able to participate at elite level?

? – yes, yes

? – I think the same

Stamina is appreciated as a masculine ideal, and young aspiring athletes learn to cultivate stamina to enhance their chances and build up their careers. The teaching of stamina and toughness is introduced to boys and girls in pre-school football teams, a controversial phenomenon recurrently debated in the newspapers. The current is that you have to endure the strains and pains, and always work hard to push your personal limits another inch to reach the top in any sport. Team mates, who scream in pain for seemingly minor injuries, get the look of disapproval. This illustrates Goffman’s body idiom; performance communicate, and are interpreted according to institutionalised schemes – as either appropriate or inappropriate to the situation. On the sports ground however, strategic faking is a part of the game, as well

as real injuries and extreme pain. Faking implies both faking pain when fit, and faking fit when being in pain. Either way displays of pain may irritate team mates if the pain-incident weakens the team's performance, but please them if faking enhances their performance in a match. Pain is a phenomenon that provokes emotions, both on the sports ground and in the doctor's office, as will be shown later. Goffman notes the paradox of body idiom, that the way in which participants can give the least amount of information about themselves, is to fit in and act as persons of their kind are expected to act (Goffman 1963a:35), as a passing strategy.

Above the discussion suggests that men and women's capacity to endure pain are more similar than alike, but that cultural advices for girls or boys differ. Chris suggests that men push their limits more than women at the sports ground, whereas women push their limits more when dealing with low back pain. As such the discussion is referring to gender as a social institution where expected conduct and deportment in particular situations are 'naturalised' due to recurrent enactments, but not biologically determined. In an interview Vetlesen cautions us about the cultural impact on how we are relating to pain: When boys are raised to endure more pain than girls, they embody a lower tolerance for others pain (Frich 2006). This is problematic if they try to export own standards of pain tolerance to other people. However, this is what we all do according to Scarry (1985), it is not a gendered understanding. Maybe the issue of pain is representing another issue all together. Pain may be analysed as a matter out of place evading categorisation, and hence a matter that threatens social order (Jackson 2005). This would account for the emphatic discussions in several groups.

As stated above, Goffman's body idioms are interpreted according to institutionalised schemes. Amongst institutionalised schemes, gender is particularly salient, operating as an institution in it self, and intersecting with, or operating within other institutions. Pain is located in the medical terrain, and the intersection of pain and gender are relevant. The (historical) gendered bias in the medical body of knowledge has disfavoured women's ill-health (Johannisson 1996;Johannisson 1998;NOU 1999:13;Schei, Botten, & Sundby 1993;Sudmann & Råheim 2001a). As an example, we know today that myocardial infarction manifests itself slightly but significantly different in a woman's body than in a man's body. It

follows that unacknowledged biological differences may lead women to communicate their pain in different words, or they may give off different biochemical signs than a man. This may accord for the historical fact that diagnoses of myocardial infarction were less often applied to women than men. The historical male bias in the medical body of knowledge ascribed a more “objective” and legitimate type of communication on pain to men; a causal link between symptoms, biochemical markers and myocardial infarction were established. In other words, there was a body idiom available as culturally shared knowledge, however biased by male standards. The A and B gentlemen’s pain was conveyed to me by a few words, because their ailments have a name which is often heard, and lots of justified stories circulate. The D-ladies, however, could not convey their pain story with few words, because there are few prefabricated or justified stories at hand. Their pain has not yet been sufficiently edited and justified to be intelligible to others, either members of the medical professions or the public. A body idiom is not yet available, and appropriate displays are hard to give and difficult to interpret. However, each telling purport circulation of stories, which eventually manifests themselves as culturally shared knowledge. Collective action changes social institutions and bodies of knowledge.

Body idioms draw on social institutions, which in turn is an interpretive scheme created by repetitive practices. By turning the tables, i.e. changing practices, social institutions gradually change. When women or men keep telling unfamiliar stories, and keep showing unfamiliar body displays, interpretive schemes gradually change. Henceforth, the English notion of medically unexplained disorders embeds a promise, not embedded in the Norwegian counterpart (diffuse lidelser). The concept ‘medically unexplained’ is temporal and situational – it does not deny the existence of a particular phenomenon, and medical explanations may be available in the future.

Pain displays

At the beginning of a new millennium, by numbers, handball is a predominantly female sport and football a predominantly male sport in Norway. Male handball and football teams precede the female teams at an organisational level; i.e. political, material and financial resources. According to the athletes, and common sense, the male teams tend to play both handball and football in a rougher and tougher manner compared to the female teams.

Whether this is due to historical time delay or physical differences between men and women (e.g. height and weight) is of minor interest to this study. In the conversation below, Cindy responds to a question about spillover between male and female sports:

Cindy – I think, generally, that the elite level sport is imprinted by the males

Tobba – in many different sports?

Cindy – yes, in many, nowadays handball is a female sport, but the bar is set by the males, because they were first at elite level

(...)

Carmen – if we are to distinguish ourselves from others [non-athletic girls], then it's the pain we talked about, the pain threshold is set by the boys, we have to endure more than a normal girl would stand, a girl not accustomed to training, she could complain louder of lesser pain than we can, because we know this is voluntary, and that the pain threshold is already set

In other words, what counts as a legitimate reason to claim pain, or which injuries are accepted as painful, is defined according to male practices and patterns of response. According to the C-ladies all female players have to endure pain without complaining, because the standards are not possible to negotiate. Moreover, female elite athletes have to impose a different body idiom than non-athletes. As female athletes, pain is an important part of their careers, but as Carmen remarks, it is a self-administered pain. Consequently, as opposed to the pain of chronic illness, alleviation is (theoretically) at hand. However, aspiring athletes endure pain and take risks to reach the top. Lupton argues that in particular contexts, risk taking may be considered part of an overall strategy of career advancement (Lupton 1999:156). The notion is that when you have reached a certain level, you have to take risks in order to achieve long-term goals, e.g. strive to be selected for championships and enhance athletic performance. To these women, when they are talking of their own experiences, the implied reference is to display an appropriate body idiom and pain behaviour by the standards designed for male athletes. Voluntary risk taking, in this sense, are rewarded with enhanced performance and an escalating athletic career. Braking boundaries have a seductive element, according Lupton, risk taking can be pleasurable as well (Lupton 1999; Tulloch & Lupton 2003).

Being in pain

“Without pain, our life is not liveable, and with severe pain life is almost unbearable. When pain is totally absorbing, it takes our life but still let us live and makes us wish for a total relief, even if it means to leave life.” These reflections are Vetlesen’s introductory sentences

to his philosophical essay on pain (Vetlesen 2004:7).³⁸ To live is to be exposed to pain every second – not always as pain de facto, but at least as an ever-present threat of potential pain. Living is a hermeneutical situation; we try to understand the world around us, and align ourselves to the situation we are participating in – whether this is in the concrete world, or an imagined one. Pain is a particular challenge to understanding and alignment. How to display pain and how to interpret pain may be inquired as a phenomenon lost in translation.

The A and B-gentlemen act on what they perceive to be childhood knowledge, part of their identity, and an important dimension of their personal agencies. They have learned the hard way to keep up with the rounds of everyday living and work life, whether they were in good or poor health. There wouldn't be any food on the table otherwise, one of the men laconically commented. They literally have endured pain and discomfort to avoid being called a sissy. They impart an understanding that hard living increased their physical capacity and achievements, as well as impaired their capabilities over time. Several of them have contracted arthritis after years of physically hard work, e.g. bricklaying. Still, they agree with the saying that 'hard work never does anybody any harm'. Both positions probably holds true; impairments and working conditions often correspond, but not always. Congenital or environmental factors may be more important.

The discussions about being a sissy stimulate an exchange of opinions about the younger generation. Their own ideals and standards are considered to represent accepted practice when comparisons are made between the young and old. Four of the five A-gentlemen participate in this conversation, and believe that youngsters are weaker today, and prefer watching the television or playing computer games. In the work place new machinery relieves workers of much of the hard graft, but the sick leave rates are high. Andrew suggests putting everyone on night shift, and is supported by two unidentified speakers. Asgeir's interpretation of this as an answer to the implicit problem definition; the young are unable to get out of bed in the morning and stay strong through a normal working day, gets a laughing response. The A-gentlemen construct their generation as *men*, doing heroic masculine deeds while confirming the masculine ideals of being in charge, outdoing other men, being courageous, physically tough and cool (Wetherell & Edley 1999). Men today are sissies, the

³⁸ My translation

A-gentlemen imply, you only have to look at their sick leave records to see malingering. This is an indirect assessment of pain tolerance – or of ability to push one’s boundaries and enter new, and probably, rewarding territories. This may also be interpreted as a representation of this generation’s conceptions of normality – i.e. what normal men ought to do and which pains they are advised to endure, and challenges they are obliged to overcome. As such, they are inscribing their own health in accordance to a larger picture, where their priorities are given privilege in comparison with the younger generation. They narrate themselves as normal men, and as such justify their ailments and entitlements.

The proverb “no pain, no gain” and its equivalent “fight fire with fire” are frequently invoked, and well known to everybody. To my knowledge, they resemble older principles of treatment. Following Gadamer every saying carries historical practices and meanings along. Young people, whether students of physiotherapy or relatives, seem to believe that contemporary medicine has better, pain free methods at hand. However, middle-aged or older people seem to have learnt through their body that muscular skeletal problems need firm and sometimes painful treatment to improve. At the same time, this principle also builds on and reinforces masculine ideals of strength and endurance in the face of pain and hardship – as well as comfort and support supplied by the therapist’s hands. Albert tells the group that he used to think of physiotherapy as a luxury, something pleasurable and expensive like going on vacation to Thailand and being massaged on the beach. A story about Thai massage came in handy as a comparison and explanation of the notion of luxury.

Albert – before I had seen a therapist myself, I thought this was some luxury

Tobba – since the lists were long?

Albert – no, more like I heard how marvellous it was, a luxury, like going to Thailand, (*laughter*) I know now that’s not the case, people get loosened up, and they get help

Asgeir – you have to pay, did that add to the notion

Albert – it’s a high status occupation, right?

Asgeir – the occupation

Andrew – you see all around, the athletes, having their own therapist, travelling around

(...)

Anthony – (...) you mentioned that luxury aspect, we are raised under similar conditions, and as you say, it’s imprinted from childhood and youth that such treatment things, that’s luxury, you have to endure, can’t run down the doors at the doctor’s office all the time, so that was deep in me, have to endure, can’t take any treatment or anything

Alec – that’s what makes it worse, just like this shoulder, I waited much too long, then there was an inflammation in the bones

Anthony – it's the culture

Alec – yes, if you had seen the therapist sooner, whether male or female

Anthony – it's deeply rooted, either you endure or you are a sissy

Tobba – that's a part of the craftsmanship culture also, isn't it?

? – yes, of course

Four of the five men participate in this exchange. Alan, who earlier recounted a Thai story illuminating aspects of luxury and massage, listens. Life story or background data are not collected. I do not have any information to suggest either large differences or similarities in growing up conditions or present social situation. The contrast between a hard childhood on a small farm and non-sissy behaviour on the one hand, and the luxury life of elite athletes and high status of the physiotherapists on the other hand, nevertheless has adverse effects when it comes to seeking help from health care agencies. The men told about enduring their suffering, and how their ailments exacerbated while postponing seeking remedies.

Nordtvedt et al. suggests that men struggle to avoid being a nuisance or bother to others, so they stifle their pain (Nordtvedt et al. 2004). When pain is recognised and acknowledged by others, it reminds the men about their loss, whether literal loss of a limb or metaphorical loss of future opportunities, which is an additional pain and constraint on their life. The participants in my study have not lost visible parts of their bodies. However, the point is not the bodily loss, but the notion of being a nuisance to your environment. Being in pain, as construed by Scarry (1985) and Vetlesen (2004) alienates you from the able-bodied pain-free community.

There is reason to question whether alienation is the result of an individualising inward attention as suggested by Scarry and Vetlesen, a result of social marginalisation due to stigmatisation of people living with chronic pain, or both. Pain is difficult to categorise, and pain displays more often than not confound interpretations, particularly when the person claiming in pain are giving off oxymoronic signs. As such, pain represent some sort of mess or threat to the social order, a matter out of place or a mixing of categories (Douglas 1994). Their presence causes distress, and induces unease. Good et al. summarise the challenges facing those who suffer and those they seek for consolation or relief.

The core conflict between pain patients and health professionals involve many factors – frustration on *both sides* over the inadequacy of therapeutic intervention, distrust over the assessment of pain and its implications for disability determinations, and

disagreement over the influence of voluntary control over symptoms and the question of *accountability*. (Good et al. 1992:8, emphasis added)

Jackson (2005) suggests that in the case of credibility, and distrust on both sides as suggested by Good et al, we ought to take a closer look at the stigmatisation of people with chronic pain. Stigmatisation is the recognition of an attribute that makes the bearer different from others in the category of persons available for him to be, and of a less desirable kind (Goffman 1963b:3). The person is then reduced in our minds from a whole and usual person to a tainted, discounted one. Stigma is an attribute that is deeply discrediting, an undesired difference from what we had anticipated. Displays take on a moral character, as discussed earlier, and oxymoronic displays are susceptible to be discredited. Chronic pain sufferers straddle boundaries and wander from category to category, Jackson contends. They threaten the ethical and normative implications accompanying the classification system (e.g. social categories or medical diagnosis) by evading attempt at classification. The chronic pain sufferers embody disorder, and are marginalised due to their possession of imperfect bodies (Jackson 2005:345). The stories told about unrecognised heart diseases or rheumatic disorders, fall into this picture. The same goes for some of the stories told by the participants in the D-groups –painfully pinpointed when David refers to be treated as contaminated waste. David failed to meet social expectations, and the interaction turned to an embarrassing situation. He was literally categorised as matter out of place, an embodied disorder threatening several classification systems. The athletes play on this classification system when pain is faked or ignored, planning for rewards but risking sanctions.

... but needs must.

When preparing the group discussions for the rheumatics (A-groups), I had expected that constraints and pain due to impoverished joint function would be a relevant topic. This was probably due to unreflected remnants of biomedical knowledge on my behalf. There was no discussion of impairments (loss of function on a biological level without assessing consequences for function or participation) in any group. The issue of pain, however, were salient in all groups – all though differently. Pain is not always a constraint or stigma; it is also a means to reach other ends. It may have individualising powers, but may also embed desirable experience promising a greater good.

In the next extract the A-ladies speak all at once, and in one voice (making it impossible to hear who says what). But they agree that the therapy will have no effect unless it is applied with force, which elicits pain. Even though, as one woman confesses, she screams in pain, another woman double up in pain on the bench, and a third woman want to walk out because of the pain, they subject themselves to therapy despite the pain and because of pain.

- ? – I don't like the machine, it's better with massage
Everybody – yes, yes
? – I've never tried a machine, its better with hand massage, and then the tender points are detected, and there they must give it all, so I can feel it
Tobba – no pain, no gain?
? – yes, it's really good
? – sometimes it's so painful I tell I have to leave
? – I scream when it hurts
Tobba – do they stop if you scream?
? – no, no, they have to continue
? – does it hurt, they ask, of course I say, then you're improving, they say
? – you see, it has to be forceful to have any effect
? – my therapist, the present one, start carefully, and increases force, had they started at full speed, I couldn't take it
? – then I'd been like this (crouching in the chair), I start with ultra sound

The women point to the advantages of hands-on therapy; the therapist can find the painful or tender points, and work hard on them. This would be impossible for machinery, they argue. Råheim's study of women with chronic pain adds to this picture (Råheim 2001). Even when in pain before and after therapy, painful therapy is deemed recuperative. Bonnie does not express mere satisfaction, she says she *complies* with the agenda – whether in pain when the treatment seems rough, or in boredom when the heat packs are left on for too long. Brenda supports her therapist in that therapy must be painful to be successful – we believe it has to hurt, she says. Radley & Billig (1996) and Good et al. (1992) direct out attention to the question of accountability. When these ladies speak of pain as a means to a better end, they speak of cultural expectations to persons claiming illness or in pain. The sick role is legitimate only for a period of time and the sick must strive to improve, e.g. by seeking qualified help and subject oneself to the recommended amendments. By accepting painful treatment, they demonstrate their compliance, and justify their claims of bodily concerns.

Several of the participants in the A-groups and B-groups had been on convalescence abroad; some of them more than once and some travelled every year. Recurrently comparisons were drawn with treatment in the Mediterranean, where both treatment and outcome were given

higher marks than comparable treatment at home. Below, Bonnie compares the experience from abroad with the one she gets locally. Gender of the therapist is of minor interest, as in most of the stories told about convalescence abroad.

Bonnie – (...) I saw the therapist same day they removed my plaster, and that was Ok, a male one, and reckoned the treatment period for my arm was quite long, a tough treatment I think, but needs must

Tobba – you had broken your arm, you said

Bonnie – yes, a broken arm, I had heat packs, while he attended another patient, and then I have been at convalescence abroad, (...) and that was also a male, a treatment program for the stay, but without those heat packs

Tobba – it was hot enough

Bonnie – yes, it was a positive experience, and now I attend a female therapist, she takes good care of me, she uses more machinery though, that's comfortable after the heat packs, but I have to wait for long periods I think, but needs must,

(...)

Bonnie – but when he was breaking on my arm, I screamed and yielded

Tobba – what did he do then?

Bonnie – (..) he just continued, it had to be painful he said, if I wanted to improve, it had to hurt, he said

Britney – that's what we think, we have to feel it to make it improve

The saying 'needs must'³⁹ is only mentioned by the women. The saying expresses their alignment in the group situation – they are complying with the expectations they meet. Parsons (1975) is emphatic to state that the sick role not equates a passive surrender or subordination. In his opinion, going along with the suggested activities is agency. The sayings 'fight fire with fire' and 'no pain no gain' are mostly used by men, but alludes to the same enactment. Britney's last remark highlights this argument. Even though they refer to plight, they are enacting compliance.

A necessary pain

In the extract below, the D-women try to explain to the researchers that physiotherapy is very painful, like a necessary evil, or unavoidable duty. This was a most unexpected perspective, and we, the researchers, were taken off guard. We had never imagined that *every* physiotherapy session could be such a torment for any patient – and still endured for years. The issue of painful treatment evolved from a discussion of bras and Daisy's description of physiotherapy as something she dreads, and doesn't feel like dressing up for. I was still preoccupied with inquiring about pleasure, and the group burst into laughter. The laughter

³⁹ Må du, så må du

probably alluded to my ignorance about their bodily concerns and experiences. Kotthoff's short and apt wording about situational comics 'being there to getting it' sums it all up (Kotthoff 2006). They recognized each other, 'it takes one to know one', and they recognise my ignorance. Eventually even the researcher gets the point, and redirects the questions:

Tobba – how about, if it was pleasurable, something to look forward to
Roaring laughter
??? – (Lots of voices) – never happened
Tobba – haven't any of you experienced it?
Laughter
Deborah – I'm dreading physiotherapy
Laughter
Diana – you don't sleep the night before
Daniela – it's like a dentist phobia, fight fire with fire, that's my credo
Diana – then all the days of recovery afterwards
Daphne – but it gets painful if I don't have the therapy also, but needs must
Deborah – you have to watch your schedules, what can I manage after therapy
Tobba – it sounds like torture
Deborah – get the work done before treatment
Daniela – sometimes it feels like torture as well
Daphne – a while ago, I said, imagine if this had been pleasurable
Tobba – please, do not misunderstand, but have none of you really never experienced pleasurable therapy?
??? – (mumbling) yes
Daisy – well, when you have the heaters, that's not too bad, but what follows
Tobba – so you dread it, and afterwards
Diana – you get ill again
(...)
Tobba – well, I have heard that some think physiotherapy are marvellous, and that this might lead to misunderstandings, one provides pleasurable bodily experiences to another, receiving, do you see that's possible
Daisy – I observe people who tell they are in pain, and I see all they manage, and I think, how about to be able to manage all that, and they enjoy physiotherapy, because they do not have as much pain as they claim
Tobba – they take pleasure in therapy?
Daisy – I believe they do
Tobba – what do you reckon?
Diana – if they don't have these painful points,
Tobba – I reckon pleasurable therapy sound absurd in this group
Roaring laughter
Doris – I try to imagine how that might be
Roaring laughter
Tobba – like, I remember once, it was ...
Roaring laughter

Five of the six participants talked more or less simultaneously during this sequence. They talked about how their daily and weekly schedules are affected by the therapy sessions. They sleep poorly, have to get work done for the next few days, and make time and space for a few

days of recovery *after* therapy. The topic of conversation in the extract serves to illustrate Scarry's argument on pain as the ideal model of distrust; there are pains and there are pains. If pain was an experience that constituted a more relational community, the one in pain should have been the first to acknowledge others in pain, and offer them consolation and support. However, the view of Scarry (1985) and Vetlesen (2004) of pain as an individualiser is recognisable. My pain is true beyond doubt, but others' pain might be a behavioural artefact. Some of the D-ladies told us about their sparse amounts of small talk with their therapist during sessions. Following the lead of Scarry and Vetlesen a bit further makes these utterances understandable. If you claim to be in great pain, turning attention inwards and withdrawing from verbal communication will justify the claim. Painful treatment legitimizes the pain that made you seek (painful) treatment.

Pleasurable therapy was the subject of further elaborations among the D-ladies, some of whom admit that the heat packs are comfortable, and the period before the manual treatment starts, when they (hopefully) can relax and let the bench support them, might remind them of pleasure. Daphne tells the group that her biggest disappoint is that they don't give her heat packs. But she puts on rice heaters at home, before rushing to therapy sessions. Everybody in the group is well acquainted with rice heaters, some of them are also involved in the production and sale of these gadgets. (We were urged to buy some!) The reluctant engagement in the topic of pleasure may also be interpreted as a warrant of chronic pain. These ladies have been subjected to all kinds of examinations, assessments and treatment regimens, and have met dozens of professionals insinuating that their pains are only in their brains – imagined, and not real. If they had admitted to pleasure in the therapy room, such insinuations get an unintended bearing. The presence of two researchers impedes revelation of this kind. Accounts given about health and illness, always relate to a larger situation than the small gathering in a focus group. The participants might view the researchers as devoid of experiences with severe pain. While keeping up our work and inquiring into health and illness, we call forth enactments which displays and thereby exemplifies conceptions of health and illness (Radley & Billig 1996).

//legitimate pain

Jean Jackson (2005) asks why is pain, something invisible and experienced by everyone, so often stigmatising in its chronic form. Pain is unlike the kinds of characteristics that usually lead to stigmatization; bodily disfiguration, blemishes of individual character, and tribal stigma of race, nation, religion or minority (Goffman 1963b:4). Jackson suggests that stigmatisation of persons with chronic pain is due to their slipping through networks of classification, that normally locate states and positions in cultural space. Drawing on Turner and Douglas, Jackson employ the concept of liminality to discuss stigmatisation of chronic pain sufferers. People in chronic pain occupy a liminal position where they are snagging to something new or back into something old, they are betwixt and between, not-quite-either, and some-of-both (Turner 1969:95 in Jackson 2005:333). Jackson also employ Douglas ideas of category mixing or matters out of place (Douglas 2002), suggesting that these concepts depict the problem of pain. Following this, people in chronic pain are matter out of place, in a liminal phase of change that represents social disorder. This disorder is deeply discredited, and hence stigmatising (Goffman 1963b). Persons in pain either have to enact displays that align them to the social situation at hand, by means of underplaying, faking or exaggerating. Or they have to create an alternative cultural space, where pain occupies a clear category. Both strategies are agentive.

In her acknowledged studies of pain and torture, Scarry creates a model of pain (Scarry 1985). She states that we are not relating to own and others' pain in the same ways. Pain as a personal experience of persistent pain, and someone else's experience of their persistent pain, differs along an important dimension; i.e. what is true beyond any doubt (personal pain) and what can be doubted (other's pain). Scarry argues that this exemplifies an ideal model of distrust. This creates a problem of communication and justification of pain – whether the pain is induced by heavy dosages of exercises and training, chronic illness, self-mutilation or torture. To my knowledge the participants in this study have not been subjected to extreme abuse or self mutilation. This is not inquired into, and of minor relevance to the argument of pain as stigma, as an individualising experience or a muting constraint upon communication.

When Annabel spoke about her doctor and how he interpreted her pain differently from her, Scarry's model of ideal distrust is explicated (see chapter eight, Communicating ailments).

Annabel understood her pain as a bodily tale about a heart condition, while her doctor refused to contemplate her version and insight. The labels he applied were muscular pain and ‘nerves’. Her point of view was discredited, and Annabel created as a complaining patient with an imagined heart condition. Being distrusted added a new dimension to her pain experience. Amy’s comment succinctly summarises the case of dramatising a credible display: “Even if there are no so called objective signs, the pains are equally disturbing and disabling.” Steihaug’s study demonstrated that physiotherapists were able to find multiple signs of ailments and pain, not detectable during regular medical assessment. She concludes that when doctors say they “can’t find anything” it depends on what they were looking for, and which assessments scales they applied. Pain can be perceived as a sign of bodily distress, rather than a representation of underlying ‘objective’ factors (Steihaug 2005), as Amy suggested above.

None of the male participants referred to experiences of being rendered suspect when claiming in pain. Pain displays intersect with gender displays, as well as with displays of other statuses that are evoked or claimed in association with pain. When men are justifying their bodily concerns and their entitlements, they are drawing on institutionalised expectation to men – i.e. generic understandings of masculinity. As men, claiming legitimate retreat in the sick role they admit to the pleasure of Thai massage. Still so, they are quick to call attention to the contemporary ‘treat-all-cure’; physical activity and exercise as a principle of physiotherapy and public health. As an example of recommended entitlements they mention the ‘green prescription’. Patients diagnosed with hypertension or diabetes II are entitled to three appointments a year with their regular GP for guidance on diet, eating habits and physical activity.

Physical education and activity is a political issue these days. The Parliament White Paper No.16 (2002-2003) “*Prescription for a healthier Norway*” emphasises the importance of physical activity for the health and well-being of the population. The Paper describes public health work as the total effort of society to “strengthen whatever contributes to improved health and impair whatever involves health risks” (St.meld.nr.16 (2002-2003)). The Parliament White Paper as well as the World Health Organisation points out that physical activity is the great health challenges for the future. The directorate for health and social

affairs' *The Action Plan on Physical Activity* (Ministries 2005) aims at increasing and strengthening factors that promote physical activity in the population and reduce factors that lead to physical inactivity. The Action Plan on Physical Activity is a national mobilisation in order to promote improved public health through increased physical activity, and The Year of Outdoor Life 2005 is a good start of the period of the Action Plan, that runs from 2005 until 2009 (Ministries 2005). When the male participants are referring to green prescriptions and increased physical activity, they are displaying their familiarity with current policies and discourses of health. This may, or may not, be in concordance with their personal views or way of leading their life.

During group discussions, some of the participants disclosed their medical diagnosis. As shown by Album and collaborators, medical diagnosis make up a prestige hierarchy (Album & Westin 2008; Norredam & Album 2007). Some of the women self disclosed to be medically labelled with fibromyalgia, a diagnosis ranked almost at the bottom of the hierarchy. This diagnosis is contested, and surrounded by a mixture of representations and denigrations. None of the men disclosed medical labels ranked bottom (or near). Henceforth, the women with low prestige labels had to display a more convincing drama to justify their complaints and pains, than did the men. Accordingly, the differences observed in pain accounts, can also be interpreted as illustrations of prestige hierarchies, and of the liminal status of pain intersecting with gender hierarchies.

Limited access to intimacy

Some parts of the body are reckoned personal and intimate, and if it is possible to choose, several of the participants prefer same-sex relations to their therapists. Physiotherapy may be an intimate situation where the therapist comes close, both metaphorically and literally. The therapist, through handling and interacting with the patient's body, has a window to the broad landscape of what it means to be a woman with physical disabilities. The diverse bodily constraints and pains have consequences for all aspects of daily life – ranging from intimate relations to spouses and children, housekeeping, leisure, shopping and work – all of which may be evoked in therapy.

Being in physical pain before, during and after therapy, and dreading the therapy beforehand, embeds a consecutive story of pain. When the body is overwhelmed by distress and pain, as the D-ladies say, they probably have fewer possibilities to enjoy dialogical or bodily closeness – whether the interactants is their spouse, lover, children, friends or therapists. The topics of intimate, sensual or sexual relationships are not explored in this study. However, there is a pervasive sense of bereavement associated with the lack of pleasurable bodily experiences and intimacy – literally and metaphorically. Moreover, as Daniela says, the therapist detects vulnerable points on her body she cannot detect herself, and there are other areas which are so painful and tender that even her husband is not allowed to touch them. Pain is a constraint for intimacy, as Daniela presents the case for the group. Råheim's studies provide several examples of this, but also of the contrary, about women with chronic pain who manage to keep up with, and even improve their intimate relations (Råheim 2001;Råheim 2004;Råheim 2006). Accordingly, even pain can be an enabler, when dealt with in an agential manner. Curiosity and creativity purport negotiations, and may detect new possibilities in all aspects of living.

Communication on pain

The discussions on pain and agential body politics featured proverbs and sayings like 'no pain, no gain', 'the medicine ought to have a bad taste to be effective', 'fight fire with fire', 'if you're in for a penny, you're in for a pound', 'only sissies complain' and 'but needs must'. These sayings are displays of health and illness, both as personal accounts, and accounts about how the person relate to the larger discourses on the matter; where the intersections of social institutions as gender and health and moral are salient.

Pain stories are made up of words that can be shared and interpreted, but mediated through the body. Pain stories are mediated in other ways as well, through appropriation of other health related resources or pain props. The B-gentlemen and the female athletes detailed pain props most: belts, braces, collars, sports tape, liniments, pillows, magnets, heaters or TENS apparatuses.⁴⁰ The B-gentlemen also appropriated alternative treatment traditions periodically (e.g. acupuncture, copping, zone therapy). The female athletes told they wore pain props to prevent further injury, as well as to communicate to their peers, counterparts and spectators

⁴⁰ Transcutaneous Electric Nerve Stimulation. Painkilling device, designed and inspired by acupuncture

that they are not giving into pain, even when they have a socially legitimate injury beneath the brace or bandage. These props were a token of a career. Having an injury but still playing on is appreciated as an expression of stamina and eagerness. Props are easily spotted on the sports ground, whereas outside the sports ground props might be hidden beneath clothes. The B-gentlemen did not wear any visible props. However, their conversation about health promoting props was quite caring and friendly; exchanging advice and opinions on their alleged effect. This talk probably equate changing room talk at the sports ground. Their accounts may be interpreted along the same line as the female athletes' accounts. They take action to relieve their bodily concerns, and keep up the rounds of daily living. As such, their props are a token of a career as well – a health career, resulting from perseverance or stamina, an appreciated display of masculinity and high moral standards.

In the last extract in this chapter, we see Diana, Deborah and Daniela having a laugh about gender and pain, about gender spillover and bodily disruptions.

Diana – I had this back surgery due to an injury in a vertebra, and I don't think this is a womanish issue, men who have back pain, do have severe back pain

Daniela – do the men have more pain than you?

Diana – they think so

Roaring laughter

Deborah – they insist

Diana – some think so

Deborah – men think they are worse off than us

Roaring laughter

The exchanges above play on a cultural trope popular with Norwegian women – when men are sick or ill, they're extremely sick or ill, surrender to the sick-role and leave the world to itself. Sick women on the other hand, keep going – at least at home, and most often at work. Such tropes often elicit laughter among women. But if women keep going when they are sick or ill, their pain is harder to justify. Pain warrants evoke distrust and suspicion. The same goes for the athletes; if they keep on playing, their complaints or pain props are subject to suspicion. How can they be in such a pain and still manage to play? The male athletes addressed the issue of distrust when questioning whether a screaming team member is simply trying to fake an injury, or is really in pain. If the athlete (or the man with a back pain) is fit as a fiddle in no time, malingering must be the correct interpretation. In the section on body idiom above, Chris and Carl touched upon the same cultural trope of gendered pain tolerance. Carl believed women postponed seeking therapy for low back pains, whereas Chris believed

men were raised to endure more (sports related) pain, an argument supported by Vetlesen's cautious remarks on gendered 'pain raising' (Frich 2006). Communication on pain is always at risk to be declined. Expectations and interpretive schemes are highly contextual and situational.

Jackson's (2005) inquiries into stigmatisation of people with chronic pain, leads her to guarantee anyone interesting in liminality to find a mother lode in pain medicine. The range of opinions, the passionate and emphatic debates, and the highly contested definitions of pain, not to forget the multimillion dollar biomedical industry, make up a mixture of interpretive backgrounds for any issue related to pain. And still, pain is an everyday experience that may lead anyone to claim a particular vantage point for participation in the debates. As an everyday experience, pain is 'normal'. But it is not 'normal' to linger with pain, or to have chronic pain, or claim in pain without *doing* pain, or even worse, claiming in pain and doing 'normality'. When turning the case, 'pain displays' emerge as an oxymoronic drama. Goffman's gender displays provide evidence of the actor's alignment in the situation. However, it is difficult to provide evidence of pain and appropriate comportment in a situation without any definition – or any social institutions, professional agreement or lore to use as guidelines.

Pain, as a distrusted phenomenon, can loosen an avalanche of questions from the one in pain. Why me? Why is this happening? Why won't it stop? Am I doomed to spend the rest of my life in pain? Pain, David Morris assumes, almost always is the encounter with meaning, it is a hermeneutics of pain, which seems to require an explanation (Morris 2003). Hermeneutics is the interplay of question and answers, but pain paradoxically put interactants at pains to find words and displays that are appropriate to create understanding. Morris avalanche of questions tie in with Douglas's description of blaming systems which move into action whenever ill-health, accident or sickness strikes. Whose fault is it? What action is being taken? By which means? What damages? What compensation? What restitution? (Douglas 1992:16) If there is no one to blame, the individual has demonstrated incompetence. Howe argues that all these questions are part of the cultural environment of sports, and kick in whenever somebody is injured (Howe 2004:117). I assume these questions are asked in the cultural environment of disability or chronic disorders and in the cultural field of physiotherapy and healthcare as well. Douglas blaming system tie into Jackson's inquiries into the liminality of pain medicine, and the stigmatisation of people living with chronic pain.

Able-bodied athletes differ from disabled athletes, as they do from disabled ‘lay’ people – yet they share fundamental experiences. It is legitimate to call attention to the constraints and efforts invested in everyday living by people suffering from pain or chronic illness, and compare their ‘training schedules’ with the schedules of those working to be selected for a championship. Extreme bouts of training are painful and often considered un-healthy, and some would advise training addicts to slow down. Compared to most people with chronic pain disorders, the athletes’ pain is self-inflicted and self-administered. The risks they face, and the pain they endure, may be alleviated by retiring from the sport (Howe 2004). But what then, - if the training schedules cannot be negotiated, if it is impossible to have a time out? Howe, himself an athlete with a disability, describes how his body intrudes his attention all the time. Unlike able-bodied athletes, you’re never “off” training or discomfort, you can never forget your body (Howe 2004:121). This is a challenge to Gadamer’s construal of health as well-being and forgetting of the body, as Svenaeus’ sensation of being home in the body. When the body ‘intrudes on your attention’ it is never forgotten. Howe is perfectly aware that athletics increase the risk of (further) disability, but argues that regular care, massage and physiotherapy help reduce chronic injury (Howe 2004:121). Howe is a welcome messenger to many of the respondents in this study – giving hands-on therapy another argument in its favour. More important, he is forwarding agency, demonstrating that transgression of bodily boundaries and declination of advices of easy living, open up new territory and makes new purposes possible. The price he is paying makes this a good bargain, after all. Reading between the lines of his book, he claims to be in perfect health.

Communication on pain, and displays of pain, is difficult. Much get lost in translation from personally lived and narrated pain to medical models and language. Steihaug’s studies demonstrated how communication on pain can be edited by the professional, and hence made intelligible and justified through the physiotherapist’s assessments and reports. Gadamer’s advice is to remember that there is always much that remains unsaid when one says something. “There is a lot in the same direction of meaning that almost completely escapes our attention because of the abstraction contained in the concepts of modern medicine” (Gadamer 2007:417-8; Gadamer & Grondin 2006). Pain is a paradigmatic example. Gadamer, in his conversation with Grondin, insists that being that can be understood, insofar it can be understood is language. This contains a limitation, he says. What cannot be understood can

pose an endless task of at least finding a word that comes a little closer to the matter at stake. Again, pain is a paradigmatic case. If pain is reconceptualised as language, Gadamer's advice is to remember that every language is teachable. Thus, persons are capable of overcoming boundaries represented by language, when they seek to reach an understanding with each other. If understanding pain is the end, then curiosity and aesthetic sensitivity are the means. Gadamer spoke several European languages, and all the classical ones. He contends that human beings that try to express themselves in a foreign language, however badly things go, will still find a good will on the side of the local speaker. It sounds paradoxical, Gadamer argues, but it is true; one more easily makes oneself understood in the stuttering of a foreign language than when one tries to be understood by each speaking his or her mother tongue (Gadamer 2007:417-8; Gadamer & Grondin 2006). Steihaug's studies gave evidence for this perspective; bodily concerns can be detected and edited to be intelligible. Gadamer's perspectives are here translated to a hermeneutics of pain, as suggested by Morris above.

Closing remarks

This chapter related to pain as a paradigmatic exemplar of how spoken and bodily communication, self presentation and gender intersect in physiotherapy. First and foremost this chapter stated pain as action. The participants may be construed as equilibrists, trying to act and perform in accordance with their own embodied knowledge and priorities, as well as create and relate to acknowledged accountable body idioms and pain displays. These strategies cut across age, gender, impairment, disability and social context, and demonstrate how personal vested interests are played out in therapeutic encounters. Whether elite kick boxer, living with a severe disability, having a heart disease or chronic pain, they all engage in edgework as challenging bodily, culturally, medically or personal boundaries, and surreptitiously enjoys the benefits of voluntary risk taking; periodically increasing pain for a greater good. Pain is a hermeneutic phenomenon; there is always another question to be asked, and never a last answer. Paraphrasing Butler pain is a bodily field of play, a basically innovative affair, which is put on under constraints, daily and incessantly, with anxiety and pleasure (Butler 2004a:164).

The next chapter is weaving together the issues of spoken and bodily communication, self presentation, gender and pain – reconstructing human agency as body politics.

10. Agency: Enacting body politics

The ontological premise of this study states any human being as intentional. Intentionality is described as agency, as a condition of being in action, and the means or mode of acting building on understanding of the situation at hand. In this chapter the issues discussed in the previous chapters – dialogue, touch, self presentation, gender and pain – are tied together to detail what people are *doing* to reach their personal aims and to promote wellbeing and/or health. The participants in this study have talked about bodily concerns, ranging from pleasurable to painful experiences, from voluntarily engagements in bodily endeavours to congenital or lasting challenges, within a larger social context of everyday living. The participants present themselves as intentional human beings, acting upon their life conditions in order to sustain, change or improve the issue at stake. Physiotherapy is but one of the actions or remedies considered. Accordingly, physiotherapy as *therapy*, is not *the* subject matter. Rather, the talk and interaction in the focus groups construe physiotherapy as a window on health and illness.

Volatile body idioms, politics?

There is a saying in Norway that goes like this: ‘Wherever you turn, your bum is always behind you’. I have heard this pithy comment, more than once, from people leading constrained lives. A more polite rendition reads ‘wherever you turn, whatever you do, you are never able to escape whatever it is you try to get away from, the problem remains the same’. This is part of the picture of how it is to suffer from for instance medically unexplained disorders.

Angelica – you look healthy, right

Annabel – it’s better to call it myalgia

Tobba – do you have to look ill to be ill?

Angelica – yes, yes

(...)

Annabel – but you need surplus energy to stand up for yourself

Tobba – but that’s not the case when you are ill?

? – if you are not healthy, then there’s no surplus energy, then you just lie there, and accept whatever they are doing to you

Alexandra – and if you’re like me, too idle, then they think you are healthy, and they discharge you and send you home

David – my experiences are like in the office hours, then I must be ill, but when they are off duty, then, in a way, it doesn't matter, thank you!! (thumbs the table with extra effort)

These short extracts exemplify some of the challenges facing people who are “different in the wrong way”, who demonstrate a “difference” to people in full health, if not a “diagnostic difference” according to the accepted categories of disorders. Being “different in the wrong way” implies an inability to socially justify one’s concerns or disorder; by looking too healthy, expressing pain in unfamiliar (to the doctor) ways, or being idle. The women’s body idioms, or displays, can not take on a life of their own; they are intimately intertwined with interpretive schemas as gender, class privilege, age, medical body of knowledge, the doctor’s (or other providers’) embodied knowledge and experience. Werner and Malterud summarise this challenge as “a subtle balance between being too strong or too weak, too healthy or too sick, too smart or too disarranged” (Werner & Malterud 2003:1414). The women with chronic pain not only struggle for their credibility in encounters with doctors, but also to keep up their self-esteem and dignity as women. ‘It is hard work behaving like a credible patient’, is the title of one of these articles. Werner et al.’s findings are also reported under the expressive title ‘I’m not a kind of woman that complains of everything’ (Werner, Isaksen, & Malterud 2004). The extracts rhyme with these insights, and remind us that hard work is not restricted to women’s encounters with the healthcare system.

However, the background resources available to patients or providers – the Goffmanian displays and body idioms, or the contemporary social institutions – are constraining men’s agency to a lesser degree. As men, they are given cultural licence to proactive behaviour, and more often than women, their diagnosis are given higher prestige rankings (Album & Westin 2008; Edley & Wetherell 1997; Wetherell & Edley 1999). David’s story on office hours and cultural license are too short to be interpreted fully. When all his accounts on this matter are taken together, they may illustrate an interesting paradox, where expectations and cultural licence are changing by time and context. Instead of trying in vain for resolutions, Billig suggests that the contradictions be embraced (Billig 1991; Billig 1996). Thinking, as doing, is dilemmatic and paradoxical. We are both constrained and enabled by diverse body idioms and social institutions. However, embracing contradictions as an intellectual exercise probably differs from living the spirit of contradictions.

To further this discussion, the intersections of embodiment and agency will be coined as body politics, extending the meaning of Henley's concept (Henley 1995). The notion of *politics* commonplace refers to social relations between people, or activities and affairs involved in managing (something or another), and the opinion you hold. Politics, as a concept, is related to *activism*. Activism may be explained as the attitude of taking an active part in events in a social context. In the present context body politics is related to identity politics. Identity politics is a phrase that has come to signify a wide range of political activity and social mobilisation (Heyes 2007). There is no straightforward criterion that makes a political struggle into an example of 'identity politics', Heyes argues. The term signifies a loose collection of political projects that articulate a collective that has hitherto been neglected, erased, suppressed or suffered from injustice. It is a demand for recognition of the very grounds on which recognition preciously has been denied. Heyes lists second wave feminism, black civil rights and indigenous population rights as examples of large scale social mobilisation in USA. In a Norwegian context, the temperance movement, the linguistic movement, the labour movement or the religious Haugianism movement are examples of large scale social mobilisation around one particular criterion. Identity politics tropes in the 21st century continue to influence political claims, and an extensive literature approaches disability (Heyes 2007). Different groups demand recognition and respect for oneself *as* different; it is *as* disabled, *as* hard of hearing, *as* a social minority that respect is reasserted. As an example, the Deaf movement (capital D intended as an opposition to deaf with lowercase) identify as a linguistic minority. In their view, the cultural imperative on spoken language, and more recently, the medical imperative on cochlea implantations is conceptualised as genocide of an undervalued and stigmatized culture (Breivik 2005a; Breivik 2005b; Ladd 2005). Pressing their case to comparisons with genocide is experienced as necessary to forward the argument on being Deaf as belonging to a linguistic minority.

What is crucial about the 'identity' of identity politics in Heyes' reading appears to be the experience of the subject, especially his or her experience of oppression and the possibility of a shared and more authentic alternative. Shakespeare, an acknowledged a much cited scholar in the field of disability studies research, is critical to the contemporary focus on oppression as the major constructor of disability (Shakespeare 2008:11-14). Implicitly, if oppressions and discrimination were lifted, there would be no disability remaining. Social inequality, oppression, discrimination and injustice are undisputable social fact, but they are not the

result of disability as such. Shakespeare and Mackenzie & Scully call attention to impairment and embodiment, and the intersections of class privilege or disadvantage, gender, ethnicity and other societal and material conditions of living (MacKenzie & Scully 2007; Shakespeare 2008).

Accordingly, body politics is best understood as *personal* agency, challenging dominant characterizations and social expectations, with the goal of greater self-determination on an individual level. Body politics, as identity politics, is a demand for recognition of the very grounds on which recognition has previously been withdrawn or denied; i.e. what is demanded is respect for oneself *as* this particular body, with its imputed constraining or enabling differences. When the public accounts of disability are available alongside those of footballers or other celebrities, the more body idioms will be available to actors and interpreters alike. Collective actions change and create body idioms.

Devoted player or whimpering sissy

In physiotherapy, as in sports and everyday life, the athletic or disabled body has to perform and/or pass according to social requirements and/or personal choice. When the body is the site for judging one's achievements and performances, both athletes and patients craft a personal strategy or body politics. The proverb "if you're in for a penny, you're in for a pound" uttered by Carmen in the extract below is a pithy comment, foregrounding the connection between effort, self-sacrifice and a desire to reach top level performance. Every athletic *body* is inscribed with the results of these efforts; scars from surgery, slippery joints, painful joints, painful backs, tendonitis and so forth. All the same, they seem to agree the benefits outweigh the cost – so far.

Carmen – I went to this naprapath before Christmas, my shoulders were painful, I couldn't hold my pencil, and the exams were soon due, so safety first, I'll see what he can do, and he got at me (...) but I have embodied the idea that you have to endure, push a bit further, don't give in, be tough, but then the treatment and recovery periods get extended, so next time, I think, I'll go a week too early instead of a week too late (...)

Cindy – regarding kickboxing, frankly, that's a pretty macho milieu, something always happens, little toes in wrong angles and alike, that's part of the game, it's seldom there are any really serious injuries, except a girl that dislocated her knee due to weak tendons or muscles or something, she collapsed, that's ok, but the aim of the game is to knock your opponent down

Carmen – if you're in for a penny...

Cindy – yes, that’s the way it is, because it’s all about fighting and ravaging
Being a devoted player is equivalent to pursuing your goals and pushing your body as far as it can go. Carmen did not complain about her painful arm, and hence did not take any action to speed up recovery or diminish the pain, until she found herself unable to write her exam paper. When their athletic body politics interferes with their non-athletic activities, the tables are turned. She finally sought out a naprapath, who immediately gets at her for contacting him too late. Her performance in this setting is totally different from when interacting with the team physiotherapist. Cindy’s story about a fellow team mate who dislocated her knee highlights the same point. Cindy accepts that her mate collapsed onto the mat because of the seriousness of the injury, but adds that it takes a self-sacrificing attitude to participate in kickboxing. As she says, the point of kickboxing is to knock down your opponent. Cindy’s accounts are cognate to male wrestlers’ accounts of ‘ravaging and fighting’ – you have to take on a certain amount of risk to succeed (Smith 2008).

The bodily marks, temporary or recurrent impairments or acute injuries, should as a rule not be treated as an excuse to get out of training or matches. You rather take the necessary precautions, they tell us. Ignorant in the field of sports, I told I had noticed that almost every ballplayer (at least in matches on the television) wear some sort of props – maybe to relieve pain, to maintain a certain temperature, to brace up or increase stability or other purposes not known to me. These remedies are not hidden beneath clothing, but shine like distinctions or orders, and seem to be a part of a well-designed appearance. They seem to fulfil other functions than mere prevention of injury. This is the backdrop for the question I pose below.

Tobba – is it all right to enter the floor and you have four props and you have none, that are visible

Laughter

Carolyn – everyone can tell you’ve been around a while

Catherine – it’s almost cool

Tobba – it’s like grading

(...)

Carolyn – if I hear a story about people who never have been injured, then I think, is that really possible

Cindy – then you haven’t made any sacrifices

Tobba – it’s a defensive player, right?

Carmen – yes, that’s what it is

Carolyn – everybody have a sprained joint or a tear across something

Carmen – that’s the way it’s supposed to be

Carolyn – at least at our team, there’s something with everyone

The props are tokens of a career, a proof of self-sacrifice, and a sign to others not to take one as a sissy. Everybody joins in to underline this point. You can't brag about your career unless you've had injuries – it would show you up as a sissy and unreliable team mate. However, not all injuries enjoy the same status. There is a prestige hierarchy to take into consideration, and there is a level above which more injuries can only diminish your prestige, because you are not able to participate in the games. Interestingly, the male professional wrestlers' accounts are more than cognate to this. Taking pain is action, it not passive suffering, and it is attractive, because it is given meaning as a sign of authentic performance. Physical suffering at the sports ground is experienced as a way of bonding, and a way of reinforcing local hierarchies (Smith 2008:147).

Thing (2001) contends that when female ball players are expressing aggression in playing, it is not a reproduction of male aggressiveness. Play-aggression in sport is a learned, symbolic performance – a game in the game – performed by male and female players alike – and which can be connected with a feeling of joy and excitement (Thing 2001:285). Thing observed that the ideal was to use the body in a hard physical way, an observation the accounts above support.

Qualifying injuries - Pre-empt suspicions and hypochondria

Male and female athletes qualify their injuries. The athletes subject their injuries to scrutiny in ways that “ordinary people” with the same injuries would not do. On a biological level, the impairments might be almost identical, but the interpretation and the significance read into them, and the measures deemed necessary, differ considerably. On the one hand, there are injuries which heal without assistance, but still are treated by physiotherapists to speed up recovery. On the other hand, there are injuries which ought to be treated to reduce sequela, which are ignored by the athletes. This lack of treatment is usually connected with embarrassing injuries, or injuries that would prohibit participation in a match or training if known to the trainers. Consequently, there is a delicate balance between seeking and avoiding treatment and help, the goal of which is to enhance your performance and achievements, and avoid being suspected of hypochondria, being a sissy, or of taking on too much risk. As with the female ball players above, these accounts are cognate with the male pro wrestlers' when it comes to ignoring and hiding injuries (although the impairments differ significantly).

However, veteran wrestler can show more pain and injuries than newcomers without risking their prestige or be looked upon as a sissy (Smith 2008:141).

There are inherent conflicts between preventing injuries, seeking therapy before things get out of hand, and keeping a “fit as a fiddle” image in relation to the trainer. We did not question the professional secrecy of the therapists. Subsequently we do not know if the physiotherapist officially or unofficially inform the trainers about the players’ treatments and injuries, i.e. if the physiotherapist leaks or shares sensitive information with the trainers. In the extract below, the male athletes talk about a trainer to whom only a broken leg counted as a proper injury. The participants are, ideally speaking, in favour of seeking help within a reasonable period of time, but prefer to keep their trainer in the dark.

? – our last trainer, he was like that, only a broken leg was a proper injury, it’s a bit better now, if you’re in pain you can calm down a bit

Asgeir – so you keep fit while recovering

? – then you’re ship shape in no time, as opposed to a injury proper, when it takes lots of time

Charlie – because if you’re injured, there’s only a limited number of matches, so you better hurry to the therapist and speed up recovery if possible, but there are some injuries that are in need of rest

(...)

Charlie – if you want to play, you never tell the trainer that you have pain in your thigh or your knees, if you think you can manage

Injuries are scrutinised by the athletes before second opinions are sought. One consideration is whether the player can play or has to take time off. There are only a limited number of matches during the season, and everything is done to ensure that they play in as many as possible. When an injury needs treatment, other considerations arise. Football players often suffer injury to what they conceive of as intimate parts of the body (groin area, buttocks), and as a result they assess both the problem and their therapist before deciding whether to contact the physiotherapist. When intimate parts of the body need treatment, they wonder what the therapist thinks. One of the male athletes mentions a safety first strategy: see a male therapist. I propose a connection between treatment of this particular part of the body and the therapist’s sex, and wonder if this is one reason for the fact that female therapists are conspicuously absent in male football. Carl adds that some female therapists are present, but they mostly attend to taping joints before and after matches, and to acute injuries. According to these male players there seem to be no difference between male and female athletes concerning their need to thwart suspicion of hypochondria or misunderstandings that they are

seeking therapy because it gives them pleasure. Treatments of 'intimate' and embarrassing injuries make people laugh in both groups of athletes – these are shared experiences, and the embarrassment well known.

'Wait and see', is the injury recipe applied by the female athletes. Arnhild asks if the feeling of 'at last, I've got a qualified injury' is pleasurable. The rejoinder is laughter, which can be interpreted as an acknowledgment of Arnhild's suggestion of pleasure when the injury is qualified for therapy. Carolyn calls attention to one more aspect of assessing injuries. As athletes, they are often worried that the therapist will ban or reduce training intensity. The outcome is "a day with no training is a day with no bearing". Because they want to attend training schedule, they put up with the pain. Conrad agrees –therapists can impose restrictions that are counterproductive to your goals, i.e. participation in training and matches.

Carolyn – I would like to add, (...) I ask myself, does this qualify for help?

Tobba – is it enough?

Carolyn – it's more like is it stupid to see a doctor or physiotherapist with this

Cindy – you are afraid of being labelled hypochondriac

Carolyn – yes, that label, right, I don't want to be a hypochondriac, but lately, my shoulder, I just think, wait and see if it passes

(...)

Arnhild – and if it is qualified, then it's pleasurable?

Laughter

Carolyn – if it's a tendonitis you can endure, then you can play, but it's boring to skip training, nothing else to do, just to avoid worsening, if you see

Conrad – (...) I believe a lot of athletes, as opposed to people in a regular job, who run to the therapist whenever they get low back pain, but the athletes, if you get low back pain and then see a therapist, and he advises you to calm down the next 6-8 weeks, that's no option, you like to play all the games you can, so hiding is the better strategy, and let time be the cure

Cost-benefits analyses seem to be evoked when dealing with injuries. Thing's studies of rehabilitation of sports patients in the physiotherapy clinic lend support to Conrad's concerns (Thing 2005b). She argues with Gadamer (1996) that the body regimens in the clinics mimic long-standing physical regimens in which the body is viewed as a functional biological machine, rather than as a subjectively lived. Disciplining of the body injured by sports takes place in the interaction between therapist and patient, where surveillance and control are exercised. The patients or athletes were often guided at distance, and guidance consisted of verbal information on self-care. In Thing's study, the patients did not have a direct say, and their personal and social resources were not utilised (Thing 2005b:184-5, 190). Taking

bearing from Thing's analysis, attending the clinic for treatment, and simultaneously claiming fit for full training schedules makes for a difficult encounter. Some of the impairment referred to as embarrassing, might take their bearing from this kind of dilemmatic situations.

If people suspect a person faking an injury, they are more likely to consider you a sissy or a hypochondriac. Being recognised as a devoted athlete with an injury, i.e. a credible patient, is vital, especially when your body politics is built on an ability to endure pain and recover from injuries without making a fuss or seeking professional assistance.

Carmen – I think, it was the way they received me, not the treatment, I came to her (physiotherapist), no one knew what was the matter, but she reassured me that there was something wrong, but she needed time to detect it (...) and I felt, alas, a person who believes there's something wrong with me, because I'm the opposite of an hypochondriac, I never see a doctor, there's nothing wrong with me, it ought not to be either, but then I was received by a person who was used to this, she recognised the 'wrong', I don't know, it's something about being believed and trusted

Several therapists in Carmen's experience, failed to understand her problem, and she felt they accused her for exaggerating a non-existent impairment; i.e. being a sissy – a situation dreaded by most athletes. When she eventually met a particular female therapist, she was treated in an affirmative manner, and reassured that something was wrong. Carmen's body politics was challenged when her knee collapsed, and her accounts were dismissed as irrelevant. As the women with chronic pain in Werner's and Råheim's studies (Råheim 2006; Werner 2005), as well as many of the A and B and D ladies in this study, Carmen got a taste of being "different the wrong way", of presenting symptoms that were difficult to explain medically. In these situations her paradoxical performance – claiming in severe pain and still playing – did not elicit curiosity, but scepticism from several health care professionals. She did not perform her part as a good patient as expected. Goffman's *Stigma* illuminates the issue; Carmen faced the question of how to manage a spoiled identity (Goffman 1963b).

Tough or embarrassing injuries

As with non-athletic impairments there is a prestige hierarchy of sports related injuries as well. An acute injury where you are not personally responsible is a tough injury, according to

the athletes, whereas problems caused by wrong or too much training are embarrassing. The latter could (and should) be avoided. This prestige ranking corresponds to Album's findings where an acute heart attack (personal responsibility played down) is ranked above fibromyalgia (personal responsibility for wearing oneself out highlighted) (Album 1991; Album & Westin 2008; Norredam & Album 2007). As a result, the athletes do not tell their team physiotherapist about embarrassing pains or mal-functions, as Carmen describes below. For her, because she had impaired herself, seeking help was just too embarrassing.

Carmen – injury due to overload is embarrassing, injuries proper are though, as when my cruciate ligament were torn, I had this huge brace, they called me Forrest Gump
(*laughter*)

(...)

Carolyn – (...) and sometimes I have just stepped over in a hole or something, hello!
(*laughter*) that's not supposed to happen

Carolyn adds that if she or her team mates accidentally run into a player on the opposing team, and sprain an ankle, it is considered a proper injury. But if you accidentally trip over, or stumble on uneven surface and sprain your ankle, then the injury is embarrassing. The latter kind of injury is not supposed to happen. Carolyn confesses she has bought herself an ankle brace to prevent further injuries to her ankles, she has had enough. More comments emerge during the session, the essence of which is the same: self-inflicted injuries are embarrassing, and injuries caused by the actions of others are tough. If someone else is to blame, the injury transforms into a tough bodily inscription, and if you endure self-healing as well, the inscription gets deeper (Douglas 2002:15-16; Howe 2004:117). Self-inflicted injuries, by contrast, can leave bodily inscriptions as well, which are interpreted as stigmata – a bodily mark of a spoiled (athletic) identity (Goffman 1963b).

An important agenda in any sport is to prevent injuries, but at the same time demonstrate your willingness to make a sacrifice – i.e. by exposing yourself to risk, having and showing injuries or ever-present pain. Furthermore, demonstrating high tolerance for pain is appreciated and builds rapport, or bonding, as amongst Smith's pro wrestlers. The pro wrestlers participate in stage shows, where matches often are fixed in beforehand. However, their performances must look as if they are real fights, with an open outcome. There's a tacit agreement to not injure the opponent, an arrangement that demands both fighters to pay particular attention to choreography and synchronise their movements. Among other signs put in play, the realness of the fight is demonstrated by taking and giving pain (Smith

2008:134). Injuring an opponent beyond the show-effect is devalued, even amongst pro wrestlers. When Howe and the female athletes suggest that injuries caused by inattentive opponents are though, there is probably more to this issue than revealed in the group discussions. Recurrent references to embarrassment, and subsequent laughter, support to Howe's arguments (2004).

Legitimate retreat, Wailing Wall and support

The female athletes prompted us to ask them if they can draw attention to a particular dimension of femininity, something reminiscent of Sleeping Beauty, which encourages a male physiotherapist to take on the role of comforting and protective Prince. The women involved in different sports and being different individuals, did not agree on this matter. However, Carmen tells us that it was a wonderful experience to give into and subject herself to an unknown Swedish physiotherapist, and let him treat her tendonitis which she considered self-inflicted and embarrassing. Her tendonitis was considered a non-athletic problem, and was dealt with outside the athletic frame. Playing on the image of a poor little blonde, she enjoyed extended therapy sessions. Carmen would never play this role to the team's physiotherapist – he never gets to see anything else than the tough persona. Choreography is contextual.

Carolyn understands and appreciates Carmen's poor little blonde strategy, and although she does not have similar personal experiences she is not immune to the idea of playing "The Blonde". Cindy is not able to see herself in a corresponding situation, not even outside the athletic frame. She laughs at the very idea. Carmen repeats that she found it very pleasurable to relax in this situation, especially since it takes a lot of courage to call for an appointment. She confirms my interpretation of this *legitimate* break as a sanctuary. Claims of exemption from ordinary obligations and expectations are part of the sick role (Parsons 1975). We did not introduce Sleeping Beauty and the Prince to the D-ladies. However, Daisy's and Doris's experiences in the hands of their male therapists make sense in this picture. Therapy for them is painful, and they dread it, but they still subject themselves to therapy and accept his protective, well-manned treatment. The Blonde and the Sleeping Beauty are ready made public accounts of a stereotypical performance, a body idiom easily invoked in the

discussions. Stereotypes may be enacted strategically as well, they are both literal and figurative tropes (Goffman 1969).

Applying Goffman's dramaturgical concepts of front stage and back stage (Goffman 1959;Goffman 1974), we inquire further into the topic of wailing and complaining at the sports ground. Where do the athletes go to shed their front stage persona, retreat to a backstage and unburden themselves, complain and wail, and receive social and emotional support? At the front stage all masks and performances are kept to the golden standard (tough girls/boys), while at the back stage you are permitted to unburden yourself, your dislikes, loathing and strains, and other things (weary girls/boys). Cindy is particular with whom and where she discloses vulnerable issues, and doesn't quite agree with the point of departure of the discussion – the need for retreat. Complaints are not commonplace in kickboxing, and if there are complaints to be made they are doled out in acceptable small portions. Up to a point, complaints bring about comfort and support, while overdoing wailing is met with a grim reminder about voluntarily participation, or advice to quit the sport.

Cindy – I have the impression, since my sport is quite tough, then my closest friends think it's ok to complain a little (...) because I'm tough, I feel that I can get too tough, and only present the tough side to others, and then it's all right, though scary, really scary, to present a weaker version, sometimes, to someone

Tobba – isn't there a certain limit, if you complaints are careful, then you receive support, but if it is too much, then they get at you to get out of that terrible sport (...)

Cindy – I've heard that a lot, why are you doing this, it's far too tough

Tobba – especially in your kind of macho milieu

Cindy – my mother is a devoted opponent, she won't hear a word, she wants me to quit, she said that from the very first day

Laughter

Cindy has friends, male and female, who are supportive, but her mother loathes kickboxing. Kickboxing is a tough macho enterprise, to quote Cindy, and women have to prove their capability all the time, not only in scheduled contests. Being a kickboxer seems to invade your life in ways comparable with chronic illness or pain – there is seemingly no letting go. Pro wrestling apparently does the same, as elite level sports invades the lives of disabled athletes around the clock (Howe 2004;Smith 2008). Gender intersections are salient.

Doing gender – performing femininities and masculinities

The notion of doing gender sounded odd to many of the participants in this study. In spite of this, the discussions produced numerous examples of gendered doings. The female athletes provided two examples of what they regarded as doing gender, both of which they maintained were relevant to sport performances and physiotherapy. One concerned the difference of raising girls and boys. The other was about cultivating stoicism and stamina.

The first example of doing gender was provided by Carmen, recounting a theory provided by her trainer about the intersection of gendered growing up conditions and risk of contracting cruciate ligament ruptures. If girls are raised differently from boys, they gain different bodily experiences whatever their age. Subsequently they develop different bodily resources and skills, and different risk profiles. Carmen's handball trainer tells the players to throw their (future) daughters into the trees, and let them fall down. Hard landings (on your feet) in early childhood are supposed to increase muscular stability around the knees, and prevent injuries in adolescence and adulthood. The group bursts into laughter at this absurd scenario, but remember seeing little girls walking their doll-strollers and run home and cry for minor bruises, and boys fighting until the blood drips. The group do not detail personal growing up stories. Still, their own childhood and adolescence are embodied knowledge of personal physical endeavours; memories about other girls' and boys' behaviour and own and others caretakers' inhabitation or facilitation of their development. These embodied memories are gender displays or body idioms invoked in social interaction.

The second example of doing gender emerges when we observe that the female athletes' body politics have elements that are more often used to describe masculinity than femininity, or are called upon to demonstrate male gender accomplishment: stoicism, being in control, outdoing others, enduring pain, not complaining or bothering others with your ailments or pains, developing a robust stamina, being particular about preferences, and being able to subjecting oneself to a collective enterprise, as in team sports (Edley & Wetherell 1997; Nordtvedt, Elstad, Heggen, Bengtsson, & Engelsrud 2004; Smith 2008; Wetherell & Edley 1999). Kickboxing, which is Cindy's sport, builds on these appreciated masculine ideals, and especially cultivates the individual athlete.

Wetherell & Edley (1999) investigated how men talk and take on the social identity of being a man. They identified three patterns that men used to describe their masculinity and position themselves socially as men. *Heroic* positions aligned themselves with standard masculine ideals – being in charge (work, competitive athletics), outdoing other men, and being courageous, physically tough and cool. In the second pattern, *ordinary* positions, men described themselves as just normal average guys. In the third pattern, *rebellious* positions, they described themselves as flouting social expectations of masculinity (they could cook, cry, knit, and wear jewellery and so on). Even the seemingly alternative positions, *rebellious* and *ordinary*, were explained and justified in terms of their personal strength, independence and autonomy – i.e. the justification gets its bearing from heroic masculinity. Crawford and Paechter remark that Wetherell & Edley’s study shows discursive constructions of masculinity and femininity within particular sets of social arrangements, and should not be employed as evidence of universal or even broadly cultural differences between the sexes (Crawford 2003; Paechter 2006). The discussion in the two groups of athletes may illustrate this argument; personal strength, independence and autonomy are appreciated and justified within the all sports areas they represent. Masculinities and femininities emerge as plural constructions.

The male athletes invest a lot of time and energy in their sport, and hope for an athletic career, as do their female peers. But being an athlete at the top takes more than mere skill and grace in the sport. A football player is a performer as well as an athlete. When Asgeir raised the topic of performance, he used David Beckham as an iconic exemplar. The male athletes reported that several players do their hair before the matches, without confessing to the same habits themselves. However, Charlie said that he controls what he says during matches. Swearing and cursing affect the impression the spectators get. In other words, he takes his audience into account when playing and performing – not only the other contestants on the pitch. Beckham plays with gender, a paradigmatic exemplar of the new metrosexual male who uses makeup, wears jewellery and female lingerie (according to the participants), and dramatises a lavish and exclusive style. My understanding of the discussion suggests that male ballplayers apply feminine attributes to their performance – e.g. relational consideration, calm language and hairdressing. Smith’s pro wrestlers are deliberately flaunting anything and everything “soft”, to avoid being seen as sissies (Smith 2008). These performances exploit stereotypic gender displays, to underline their athletic identity.

Paechter (2006) argues that knowing that someone is either a male or female says very little about how their masculinity or femininity is constructed. While most are men in male bodies or women in female bodies, how we understand ourselves as masculine and feminine varies according to time, place and circumstances. Following Paechter she warrants that masculinities and femininities (in plural denoting enactment) are the actual ways that real people enact themselves, in terms of doing gender (Paechter 2006:261-2). A woman, whether kickboxer or non-athlete, constructs and enacts various femininities that all involve significant masculine and feminine (in singular denoting ideal types or stereotypes) attributes, e.g. combative argumentative style, blonde strategy, have stamina, be considerate. A man, whether a male football player or non-athlete, constructs and enacts various masculinities that involve significant masculine and feminine attributes, e.g. act like bullying individualists in the changing rooms, and have a considerate language-usage and do their hair. Paechter's argument supports Butler's undoing gender, where she says that "the future symbolic will be one in which femininity has multiple possibilities (...) released from the demand to be one thing, or to comply with a singular norm"(Butler 2004b:196-7). Butler also argues that gender is a corporal field of play, a basically innovative affair, which is put on under constraints, daily and incessantly, with anxiety and pleasure (Butler 2004a:164). As Goffmanian gender displays or body idioms. Cindy's lived experiences with kickboxing and gender may be read as a corporal field of play and a basically innovative affair. She is recurrently challenged to negotiate stereotypical conceptions of femininity. Some of the women with disability shared these lived experiences of gender as a corporal field of play; being challenged to negotiate gender and disability.

Performing masculinities and femininities intersect age and health – as already touched upon. The men in McVittie & Willock's study relate to ideal typical representations of hegemonic heroic masculinities when describing health in old age, whereas they aligned themselves with less powerful identities when discussing ill-health (McVittie & Willock 2006). Seymour-Smith et al. reported that the masculinities constructed by doctors and nurses are consistent with hegemonic notions of power and invulnerability, and a subsequent subordination of the help-seeking male identities (Seymore-Smith, Wetherell, & Phoenix 2002). Consequently, McVittie & Willock suggest that men's delay in seeking help when required may be interpreted as transitions in identity, rather than a result of masculine ideals of being self-

made. Reading McVittie & Willock's article on older men, health, ill-health and masculinity, alongside Paechter and Butler, suggests that the enactment of masculinities changes during the life span, with a broader register of doing gender emerging as the years go by – where feminine and masculine attributes may be combined anew. However, if men, whatever their age, subscribe to subordinate masculinities when in need of help, this affirms neither their gender nor their health. Health-related encounters embed the possibility of introducing alternative gender constructions; making age-related identity transitions a strategy of empowerment, rather than of decline.

Returning to Goffman, enacting femininity or masculinity is but some of the social resources at hand to everyone, as displays, dramatisations or frames – or corporal fields of play as Butler suggests. Being a female top kickboxer challenges ideal and stereotypical notions of femininity, as well as notions of sex-specific normality, and intertwines with and infers all parts of life – both the practical daily living, and the woman's self representation and interaction. This is more than cognate to David's enactment of masculinity and disability; being a diver, hockey player and skier. Following Butler's lead, there are strict punishments for contesting the script by performing out of turn or through unwarranted improvisations (Butler 2004a:162), an argument cognate with Goffman's interaction order. Cindy then has more in common with the women with disabilities than neither of us knew beforehand – e.g. playing with gender by enacting the attributes of stubbornness and aggression.

Stubbornness and aggression

The women in the D-group make me recognise stubbornness and aggression as agency, and as vital resources to engender a body politics.

Deborah – I think, all of us that get these protracted or lifelong [impairments or disorders], we get a particular stubbornness, *I will make it!*, no one is to come here and point any finger towards anything, I usually say that stubbornness is a good quality if you only have brains to confine yourself, but lot of people don't have

Roaring laughter

Daniela – you don't

Roaring laughter

Deborah – I'm only doing a little more

Laughter

Through struggling and negotiation, they have decided on how to think and act bodily. Whether their bodily concerns are congenital or acquired, they have re-composed their life maps and revised their life expectancies more than once. Bodily disruptions are calls for new stories, and order is once again imposed upon experience (Becker 1997;Daykin 2005). A bodily encounter with a physiotherapist uncovers the body's strengths and vulnerabilities, its possibilities and limitations – implicitly their body politics are assessed as well. As patients, they expect their therapist to be supportive however they arrange their lives or do their disability. If, or rather when, they are treated in a disrespectful way, or their professional helpers, providers or therapists cast suspicion on their body idioms or imply a need to revise their life maps, they feel despair, but also aggression.

The idiom of femininity or femaleness does not come with displays of aggression. Goffman, in *Gender displays*, presses that reliance of the child-parent complex as a source of imagery is a means of extending intimate comfortable practices, from the family sphere to the outside world. This is extended domestication, he contends, where female subordination follows (Goffman 1979:9). Children, and women, are not allowed to display direct aggression towards the more superior. The child-parent complex serves as a source of imagery in patient-provider relations as well (Parsons 1975). As such, the good patient role embeds ideal typical femininity or the childish – subordination and compliance. When the women in the D-group experiences aggression, they are constrained both as women, and as patients – two constraints which reinforce each other. Men more often have cultural licence to speak up for themselves and refuse to give in to injustice or unjustified claims. As the first extract in this chapter suggests, being too outspoken as a woman are at odds with the gender display and the patient role. Turning the tables, if a man is not capable of speaking up for himself, he is considered a coward and henpecked. These folk models of women acting unwomanly, or men acting unmanly, are embodied cultural resources invoked in situations where the displays and actions are at odds with the anticipated presentation of self. The academic understanding of gender as a mixture of different displays and actions has not become firmly rooted in folk lore – or other scholarly disciplines.

The making of a body politics requires a transformation of despair and aggression into productive strategies – where stubbornness comes in handy. Deborah sees pushing the limits – being more stubborn than she recommends others to be – as a necessary corollary.

Daisy – I think, to me, and you, and I've seen it on my father for years, you arrive at a place where everything is painful, you can't do this, and you can't do that, and if I do something that I want very much, then I'm punished afterwards, but still I do it, because you can't, your brains need that you give the damn sometimes, and let run, but you have to pay

Diana – but if there's a good reason, then you can suffer a few days

Tobba – you calculate if the results outweigh the costs?

Many voices – yeah, yeah

Daisy tells us how her priorities are governed by stubbornness and aggression – without which she would be unable to take part in certain activities. The price is high, as Diana remarks, but within reasonable limits and an adequate interpretive framework they can cope with it. Resource allocations leading to “lavish” social participation, with exaggerated pain and disablement the day(s) after may not elicit acknowledgement from their GPs and therapists – but do from their own-group. Pro wrestlers face the same dilemma – to comply with advices from GP's to save what's left of their knees or neck, or to keep going. The wrestlers, as these ladies, find reward in keep going, that more than outweighs the cost. The ever-present threats of new injuries, worsening of disability or increasing pain, do not reduce their eagerness to press beyond suggested limits. Risk-taking embeds pleasure. In this sense, the participants in this study may be interpreted as cultivating risk-taking, which provides them with an opportunity to display courage, to master fear, to prove something to themselves which allows them to live life with a sense of personal agency (Lupton 1999:154;Lyng 2005). In creating a counter discourse to the highly controlled body/self, which valorises escape from control and regulation, they express a longing for a body that is more open and permeable to the world (Lupton 1999:149). While this is living personal body politics, as opposed to mere compliance, behaving well is also a part of the game.

Taking pain as action

Living with a chronic disease, ailment or disability can require a lifetime in therapy. The women with disabilities talk about physiotherapy repeatedly as a painful experience, a dreaded weekly appointment, with a substantial influence on their daily lives. A pressing question is how they make sense of this – where are the reasons for allowing additional pain

to be inflicted on a regular basis. This was a most unexpected turn of the discussion, as the extract gives away.

Tobba – ... how how

Arnchild – what’s the point?

Roaring laughter

Daisy – we keep telling ourselves we’re improving

Roaring laughter

Diana – and we do believe it

(...)

Tobba – but if you dread it, it’s painful when you’re in therapy, and it’s painful for several days afterwards, some where there have to be a reason to keep up with this.

All of you can’t attend just because you are well-behaved?

Lots of chuckling

Deborah – I think there’s a lot in that [well-behaving]

Laughter

Diana – but we do have hopes

Daniela – in the future

I was not able to articulate my bewilderment about this self-inflicted pain; I only make a stutter which Arnchild translates in to an intelligible question. This elicits a roar of laughter. If Parsons’s sick role (Parsons 1975) is used as an interpretive scheme, it is the women’s duty to legitimate their ailments and disorders, and to show that they are making an effort to recover or avoid relapse. In other words, comply with medical guidance or therapy, and as women, to work hard to fulfil their duties as wives and mothers. The social reward is cultural licence to be on sick leave, receive disability pension, and withdraw from domestic duties. However, this script is designed to fit the highly controlled and civilised body/self, and a cultural imperative of health.

“The imperative of health: at once the duty of each and the objective of all”, Foucault argues (Foucault 1984:277). Lupton extends the imperative by arguing that ‘Healthiness’ has replaced ‘Godliness’ as a yardstick of accomplishment and proper living, and that public health and health promotion may be viewed as contributing to the moral regulation of society, as apparatuses of moral regulation distinguishing between ‘civilized’ and ‘uncivilized’ behaviour. This constitutes sites of struggle and the constant negotiation of meaning, subjectivity and bodily practices. As such, the imperative of health may be considered the source of pleasure in itself, and incitement of the ‘sins’ it seek to control (Lupton 1995:158-61). The medical discourse has been and still is dominated by binary oppositions such as men/women, masculine/ feminine, self/other, moral/immoral, well/ill, controlled/chaotic,

active/passive, disciplined/unruly, Lupton argues. Consonant with these oppositions are imperatives of doing the right thing – as opposed to acting wrongly. Constraints are put on multiplicity, imagination, flexibility and creativity.

Physiotherapy is lodged in the culture of medicine, and the list of binary oppositions could be lengthened with private/public, young/old, asexual/sexual, gender-blindness/gender-sensitivity, hands-off/hands-on therapy. These discourses foster a particular subject, the rational, active, and controlled male subject who fulfils his duty to be healthy. There is little space left for other male subjects, women, the old, the disabled and those suffering from ill-health. The participants in this study deal with these discourses in their daily lives, by amongst other things appropriating physiotherapy. They seem to gain pleasure by complying with the discourses of healthiness, but also by seeking forbidden sins like passivity, enacting an unruly lifestyle or enjoying hands-on therapy. They act subversively, and create their own body politics, despite and perhaps because of the discursive apparatuses' efforts to make them do otherwise. The imperative of physical activity, c.f. National action plan on physical activity (Ministries 2005), produces both the intended activity and a desire for oppositions, e.g. passivity.

The mode of acting well-behaved imposes an imperative on the patients to trust their therapist or doctors to enact fiduciary responsibility (Parsons 1975), that is, if the encounter is conceived of as something else than voluntary risk-taking. As we have seen, attending physiotherapy may increase pain, a pain which can be conceived as self-inflicted or as risk-taking. Even though their bodies tell them that this endeavour, at least sometimes, is more than they can take, they still attend therapy sessions. They trust the therapeutic programme, and get themselves to believe it might make a difference in the long run. In the extract above, several of the participants chuckle at my comment about well-behaved women, and almost everyone laughs when Deborah chimes in to support my idea. Good behaviour may encompass trust and self-delusion as strategies to put up with therapy – or a subversive attitude. Diana ends the sequence by telling us that they all have hopes for their future. Enduring pain demonstrates stamina and agency. Being able to negotiate the terms under which women their age and ableness negotiate social norms, is part of their body politics.

Behaving well is a pro-active skill and gender accomplishment – which comes in handy in passing strategies.

This explores pain response as action, rather than behaviour. The action of prime importance could be seen as the alleviation of pain (Howe 2004:81)

Passing: over-/under-doing

Daisy elucidates the paradox that if you use half an hour to make yourself presentable, it won't be acknowledged as a feat out of the ordinary. Instead it is circumvented and turns back on you like a boomerang. The implicit message can be read as follows. If you manage to look great, you lie about the time you spent getting there and you lie about your complaints. If you are looking great, you cannot say you are in pain. Scarry's argument that pain represents the ideal model of distrust is vividly demonstrated here. The result is strategic performativity and performance – give them what *they* want, and then I can get what *I* want – if I pass.

Daisy – it's just like that, if I attend with a shining hair, and try to explain that it's difficult for me to wash my hair because I can't keep my arms up long enough, and that I have to take 10 minutes break if I need shampoo twice, they don't believe you, if you're shiny

Tobba – shining hair and makeup

Daisy – fresh makeup and shiny hair, they don't believe you

Tobba – how about, if you attend with your child, and look fresh and shine, or if you look [showing a resigned and flexed body posture] like we usually are

Lots of laughter

Daisy – I have this policy, be plain, no makeup, no stash, very common and plain, then my odds for getting help is increasing

Tobba – both as a mother and as yourself

Daisy – yes, yes

In *Stigma*, Goffman details the concept passing (Goffman 1963b). Passing is to be prepared, more or less consciously go with the majority, instead for asserting respect for your way of leading your life. The women in Werner's studies, and in Daisy's account above, deliberately play down as many of their "wrong" signs as much as possible – making up a presentation that sustains the definition of self as credible (Werner 2005). During the conversation with the D-ladies, we exchange words about the intersection and interference between bodily concerns or ailments, and attire and performance. In the extract above, by adjusting my posture I demonstrated what a tired and resigned bodily attitude might look like, the subtext

being that we all know what it's like to be dreadfully exhausted in the face of demands to look good and full of enterprise. The simple choice is to concentrate on passing – the more normal the appearance, the less you have to reveal. Nevertheless, there is a subversive potential in exploiting passing strategies. Social interaction is based upon a moral obligation to be truthful – to express oneself in accordance with the “truth.” Goffmanian passing refers to a deliberate covering of personal characteristics that are socially devalued and discredited. Following this, passing may be faking. However, passing can be interpreted as flouting social imperatives, or as a sincere and truthful presentation of self. Expressions given in any social interaction by any actor never apply the full vocabulary of possible presentations. Henceforth, any presentation is truthful in some sense. “This performance is one of a million I'm capable of staging.” A dilemma is then revealed – social negotiations of which characteristics it is justified to cover up. Gender is mandatory; most often age as well, the same goes for class and ethnicity. Disability may be mandatory in some contexts, and non-compliance is met with suspicion or aggression.

As indicated by the participants the story goes that playing on strategic essentialism (or stereotypical images), i.e. performing and passing as a ‘disabled person’ in carefully chosen settings, might increase the chances of a good personal outcome. One of the participants in the preparatory group said that many persons living with a disability do precisely this. Desmond tells of the first decade following his injury, during which he only used his wheelchair at visits at the social security office – it literally paid better. It must be added that this is a gender strategy as well; we need only to recall Carmen's Blonde-strategy outside the sports arena. We use and borrow gendered social expectations to reach particular ends (Martin 2004). These experiences illustrate that stereotypical body idioms can be put to play by the patients to reach a specific end; a higher disability pension or more physical therapy sessions. Accordingly, stereotypical schemes of gender or disability can be utilised as resources in some situations, whereas in other contexts they are constraints.

If it is a loss, it is also a gain

If you have regular appointments with your therapist for years, you spend a considerable amount of time together. Being two people alone, engaged in conversation for an hour may

build friendship and bonding beyond the therapeutic frame, and give room for learning and valuable experiences.

Desmond – if you see your therapist as much as you see your best pal, a weekly session, talking (...) I'm impressed (...) to see how the physiotherapists engage in their patients, you can't say it's only a job, because it isn't (...) the dynamics, how interesting conversations we might have, what we can reach, the depth of the conversations about essential things, you can make bonds that last forever, and I think that is quite fascinating (...) I think all people want to meet others that understand us, and then you can tell more, but of course, it requires a mutual engagement, if the therapist is turned inwards, then it stops, culminates (...) but if you have a good therapist, then you might experience a conversation that is rewarding for both (...) additionally you have a person who knows your body, your ailments and disorders, and if anything falls out of step, they follow up, on a weekly basis

Disabled rights advocates, like advocates for many marginalised groups, have repeatedly argued that vulnerability, or as in this case disability, is far from entirely negative. In fact it has a particular quality as source of knowledge unavailable to others; vulnerability may be a strength and a valuable resource (Christie 2005;Daykin 2005;Heyes 2007;Malterud & Solvang 2005;Shakespeare 2008).⁴¹ Below, some of the women with disabilities add to 'if it is a loss, it is also a gain'.

Daniela – if anyone had told me what I had to survive, I'd answered that's impossible, no one survive, they would lose their wits, but when you are inside the situation, a particular strength emerges, like you Daphne, you survived, it's a period of mourning of course, because you lose a great deal, but you survive and keep on, I think it made me grow (...) yes, I have grown on my illness, because I have learned a lot about people, I've a quite different view to many things than before, but my views hadn't changed if I hadn't been through this
(...)

Daisy – you get to know your boundaries, like no other way can teach you, otherwise you thought you knew, but you didn't, but when you attend to physiotherapy so much, then you learn to know your body and your pain and your boundaries, and I think our privilege is that we know that if we do this, that will happen tomorrow, or if we do this instead, we'll manage ok

Tobba – do you think this is only relevant to the physical body, or the whole of you?
Daisy – both; the physical pain eats your brains eventually, you get tired of being in pain, very tired actually, so your brains get as tired as the physical body
(...)

Doris – I think, you learn, the way I think about physiotherapy, you meet a lot of prejudices, and I've learned to trust myself, just ignore the sayings of the others, you're self confidence increases, you learn to detect, feel, it's not just the others that know your body

Tobba – then you don't need to get depressed because they don't believe you

Doris – no, and I use this strategy in other contexts as well, at work, everywhere, I'm clever at throwing things away, negative comments, people say a lot, something's

⁴¹ Malterud & Solvang 2005: Scand. J Public Health, special issue on vulnerability as a strength

worth listening to, but all the rubbish, get it away, and I'm not sure I've learned this if
I hadn't got so close to so many people
Tobba – and got others so close to you
Doris – mhmh [yes]

In their paper on moral imagination, disability and embodiment, Mackenzie & Scully (2007) question the basis on which we make judgements about other peoples lives, especially those whose embodied experiences are construed as “anomalous”, that is difference ascribed and justified by observation of ‘strange or deviant’ displays. They caution us about epistemic arrogance, and recommends epistemic humbleness. In their paper there are several quotes from people who have survived dramatic incidents, and have their lives disrupted in so many ways – but still deem their quality of life as excellent. This they refer to as the disability paradox; that people with serious and persistent disabilities (impairments) report that they experience good or excellent quality of life, when to most external observers these individuals seem to live an “undesirable daily exercise” (MacKenzie & Scully 2007:345). Christie, in his paper on deviance as strength, suggests these snippets as food for thought; by being blind, there are certain things one sees especially well; being deaf, there is much one hears; being mentally ill, much can be said truthfully; by not being able to work, one goes far; and by being stupid, there is much one understands (Christie 2005:7). Christie follows up by stating that we cannot live without classifying and being classified and not without evaluating and being evaluated. Strange bodily displays challenge this categorisation and analysis, because categorisation draws on ready made body idioms and interpretive schemes. Christie's snippets disrupt these schemes. Desmond's telling above is from a situation where strangeness is history, while the women's telling refers to instances of past and persistent experiences of “strangeness.” However, creating a personal body politics may be read as creating new “snippets” by challenging prefabricated interpretive schemes about disability or athletics (e.g. kickboxing).

Play and experience

As Kögler contends, hermeneutics fruitfully relate its conception of human agency to a theory of social institutions understood as both enabling backgrounds of intentionality and institutional structures of power. Further, it is not the mere existence of a stable background of social institutions, but rather the capability to make use and draw on background resources in a productive manner that makes autonomous agency possible (Kögler 2006:215).

Paraphrasing Paechter (2006) and Butler (Butler 2004b:196-7) the agency of body politics is a claim for a symbolic order in which the body has multiple possibilities, and is released from the demand to be one thing, or to comply with a singular norm. Butler argues that gender is a corporal field of play. Following her line of thought the body emerges as a gendered field of play, a basically innovative affair put on under constraints (Butler 2004a:164). Either way, the call for new possibilities for human agency is unmistakable. Along the same strand, a call for a new social theory on bodily experiences may be raised.

Radley states that the body was rediscovered by social theory through explanations of which it became (and continues to be) the site and/or the object of the actions and interests of others (Radley 1995:3). Diverse strands of social constructionist theorising have to a large extent dominated theorizing about the body. The issue is that the body has been taken to be the object of control, coercion or restraint. By bringing the physical or instrumental body into the centre of attention, they marginalise the person in her or his aspect as a lived body, Radley argues. While not rejecting this body of social theory, his main objection is that its generalised approach does not adequately embrace the fact that the body is a key expressive medium, a material basis upon which we symbolize our relationship to the world of which we are a part (Radley 1995:3-4). Radley's rejoinder is to call attention to the elusory body, which suggest activity on the part of the body-subjects themselves.

Radley forwards play as a mode of being that is irreducible to relationships of power or control, and as a prime example of the body's elusory character. When playing, there is make-believe, there's risk and an imaginative world permitting loss of self for a moment. When returning to the mundane world, it has changed. Radley (1995) explores the differences between conceptualising bodies as sign vehicles denoting some or other characteristics, or conceptualising bodies as presentations of displays (in a Goffmanian understanding), as bodily gestures expressing an alternative style of life, and to symbolise alternative ways of being. Summarising the argument, Radley contends that the body does not just signify, but is essential to the configuration of meaning. The power of presentational communication lies in it being able to articulate complexes of thought-with-feeling that words cannot name, let alone set forth. Play, the lived body and the world of imaginary forms (play) signify

experiences that appear elusive, fragile and temporary. These elusory qualities as rarely acknowledged, except in relation to minority or fringe groups Radley contends (ibid.:21).

Radley's arguments draw on Goffman, and are cognate to the Gadamerian approaches applied in this study. His discussion of the bodies' elusory qualities demonstrates that the fragile, temporary or imaginary aspects of living is a fundamental dimension of being – not a particular aspect of living “different” lives, or having impairments.

Closing remarks

This chapter suggested that the main answer to the question “What do people do to negotiate enabling and constraining aspects of therapeutic encounters?” is an enactment of intentional human agency as body politics. The participants engender their personal body politics by negotiating and borrowing of diverse cultural expectations and practices; i.e. gender, age, disability, or pain. They put their different agencies to play when utilising stubbornness and aggressions as resources, or when concentrating on passing or recuperative retreat. Whether an elite athlete, a disability pensioner, a housewife or a banker, all are empathic on the benefits gained from their everyday life with diverse bodily constraints and challenges, in which physiotherapy is included on irregular or regular basis. Due to experiences they are skilled in the art of making things happen. As a collective their actions and enactments add new body idioms and health/illness accounts to our common query of interpretive schemes. Henceforth, their aggregated actions contribute to challenge social institutions, and in the long run purport changes on a collective level, along side engendering personal gains.

The next chapter is a second interlude giving reason for the second-last chapter reflecting on the role of embarrassment in physiotherapy encounters.

Interlude

To Hanne Haavind the first step in the analytical process is taken when the existing body of knowledge proves inadequate to a specific purpose (Haavind 2000). Steinar Kvale highlights the analytical insights the researcher acquires from an interview situation itself (Kvale 1996). However, the process of deciding what the situation is telling about, what it is that is going on in a particular situation, and what one subsequently is to write about, is seldom detailed in any volume on research methods. Anne Solberg writes about the blank pages of the methods section in research reports (Solberg 1985). She interviewed two senior scholars about their research (Mathiesen 1964; Wadel 1973), and discovered that both scholars early on gained decisive analytical insights, as Kvale (1996) stressed. Even though both scholars conducted yearlong field research, their major analytical insights were gained early in the process. Ideas popped when talking with spouses, friends or during leisure activities. These methodological issues represent the blank pages in the methods section, Solberg argues, they are seldom reported. I acknowledge Haavind, Kvale and Solberg's arguments and experiences concerning analytical insights, but they do not apply to the present study. I've taken great pains to gain analytical insights, where the topic of laughter emerged as something I had to write about. The major analytical breakthrough came when I found a theoretical path to laughter. This is detailed in chapter eleven, as an answer to Solberg's request on filling in blank methodological pages.

The next chapter presents a particularly intriguing issue. In the extracts from the groups presented in the previous chapters *laughter* is indicated several times. The type and amount of laughter are indicated by qualifiers as *lots of* or *roaring* or *some*. When a line break precedes *laughter*, the amount of laughter is disrupting the flow of speech, whereas when (*laughter*) is between brackets in a sentence, the persons holding the floor is capable of continuing their argument without disrupting the flow of speech. These qualifiers and the line breaks have their origin in the first transcripts, and have followed into the extracts, in their present form. Additionally, the text preceding or following extracts often acknowledge smiles, giggles, chuckles, grins, laughter particles or the like. All these instances of laughter caught my attention – particularly when struggling with the analysis. The answer to the analytical question “What is it that is going on here?” seemed to be “They laugh.” Laughing seemed natural and impossible to ignore – both in the groups and afterwards. The participants seemed to tell me something important that I found difficult to translate. Translation took me

some additional time because we laughed as well – I had to pose the same question to myself: Why did you laugh? I started to wonder why anybody laughs, and where and how, and discovered a new research field and a huge body of knowledge on laughter and humour.

Chapter 11 is partly a methodological consideration, and partly an offspring from the group discussions that prompted a new theoretical reflection. It is offered as a contribution to help fill in the blanks when trying to make sense of a large empirical material.

11. Laughter, social interaction and embarrassment

The previous chapters suggested some answers to “*What do people do to negotiate enabling and constraining aspects of therapeutic encounters?*” These answers prompted a new question: “*Why do they need such a precariously engendered body politics?*”

Why do we have to think about how to do physiotherapy?

The premise for this study is to approach physiotherapy as a social practice. In this perspective the encounter between the patient and the therapist is a gathering in a semi-formal or institutional setting. Both parties engage to reach a situational definition, and to sustain an agreed upon activities. When all efforts pan out well, the interactants fall into play, and both maintain ‘face’ in a Goffmanian understanding. They experience congruence between social expectations, their self presentation and their participation.

However, as the historical glimpses and the empirical chapters have elaborated, the social practice of physiotherapy is a complex construction. When people attend physiotherapists due to impairments or bodily concerns, some important aspects of our common repertoire of ‘demeanour and deference’ in Goffman’s phrasing, are difficult to bring along without edition and amendment. Henceforth patients are at risk – they may fail to meet social expectations, which represent a threat to the situation.

Some matters in need of amendment and edition are suggested in the following. The first issue is self presentation, particularly the task of keeping a neat and clean personal front, with respect to encounters with physiotherapy or other health care agencies. When attending physiotherapy, the therapist are scrutinising the patients body through questioning, visual inspection and often manual assessments. A fundamental prerequisite is that every patient takes on the burden of undressing or at least changing clothes to meet expectations of visual or manual access to their body. We do not have a common lode of body idioms or folk models to teach us the proprieties of this particular situation. Common advices are emphatic on clean underwear, but do not provide further advice for demeanour or deference in a therapy session.

A second matter is soon evoked; the presentation of one’s concerns or pains. As the previous chapters have detailed, age, gender, bodily impairments and concerns intersect. Historical and cultural bias disturbs interpretation of behalf of the therapist, and distort the patients self

presentation. There are not enough body idioms available to impart the diversity of ailments, impairment and concerns. Gender and health is a particular salient issue when it comes to presentational and interpretive disjuncture. It may be difficult to reach a definition of the situation, and a common ground for interaction. Productive therefore interaction may be at risk.

A third exemplar is warranted. Social institutions represent a common cultural reservoir of social expectations and recommended interpretive schemes. In this study gender is constituted as a social institution, as is health. Medical knowledge encompasses countless body idioms or interpretive schemes on health matters. A problem arises for those who present themselves differently, who assert new or altered body idioms. Again, interaction may be at risk.

A last comment is due. Even though participants in any gathering evaluate each other by observation, spoken and bodily dialogue is the most important means for evading or evoking the oxymoronic aspects of physiotherapy. Any dialogue holds the potential to make an encounter come off, or conversely leave the interactants lost to each other. As already discussed, this threat to communication is ever present, and the patients take their precautions.

The issues mentioned above, are never dealt with haphazardly. That justifies the second question: "*Why do patients need such a precariously engendered body politics?*"

Embarrassment and social reproduction

As discussed in chapter seven on self presentation, complying with social order or behaving in a disciplined manner, i.e. fulfilling social expectations, are strategies for avoiding embarrassment (Goffman 1956;Goffman 1967:105). Whatever else, Goffman states, embarrassment has to do with the figure the individual cuts before others. The crucial concern is the impression one makes on the others present what ever the justification of this concern may be. Nevertheless, interaction sometimes goes awry. When a discord emerges in social interaction, the individual responsible for the incident may feel flustered or embarrassed. One or more individuals are unable to bring themselves into play, and experience unease or embarrassment at the situation. Some times those who witness the incident become embarrassed as well. In a footnote on the last page of Goffman's essay on *Embarrassment*, the connection between embarrassment and laughter is laid bare. Goffman

contends, that by joshing, the tension of embarrassment may be relieved. And further, the sociologist can listen for this dissonance, and imply the conditions necessary for the interaction to go right (Goffman 1967:112 n10).

Billig (2005) criticises Goffman for missing this opportunity to expand on the argument. Billig's extension of Goffman's argument is quite appealing in its simplicity; everyday codes of behaviour are protected by the practice of embarrassment. If one infringes expected codes of interaction, particularly if one does so unwittingly, one might expect to be embarrassed. What is embarrassing for the actor is typically comic to onlookers. Social actors fear this ridiculing laughter. Accordingly, the prospect of ridicule and embarrassment protects codes of daily behaviour, ensuring much routine conformity with social order (Billig 2005:201-2). Embarrassment is the social death in Billig's wording, or a social pain (Harris 2006), either way an experience people try to avoid. According to Scheff, embarrassment is a lesser form of shame, and the master emotion of social life. Siding with Billig's argument, Scheff contends that fear of shame protects the social bond (Billig 2005:219; Scheff 1990; Scheff 1994; Scheff 1997). In other words, fear of shame and embarrassment is a constraint upon social action.

Goffman did not pay any particular academic attention to developmental matters, apart from using children as a part of the behavioural image in his parent-child complex (Billig 2005; Goffman 1979). Billig points to the parallel processes of reproducing language and social order. There would be no language unless adult caretakers (and older sibs or relatives) seek to instil the codes of meaning in the younger generation, he states. Children have to accept the discipline of language to enter the world of dialogue as an appropriate speaker. Goffman's studies of the interaction order allude to the same process of discipline (Goffman 1983). Billig's contribution is to bring together research from different areas – of social order, embarrassment and laughter – and point to the fact that what is embarrassing for an individual is most often comic to onlookers. When growing up, the child learns the right and wrongs of behaviour and language, by laughing and smiling adults. (Mothers are reported to be particularly prone to teach their children through teasing.) By being teased and ridiculed for mishaps or mixing of words, children learn how to ridicule, they experience repression, and they learn that mishaps are funny to onlookers – and subsequently that mishaps are expected to be followed by embarrassment. Billig summarises this in a pithy phrase; 'If

meaning has to be socially policed, then mockery and laughter are the friendly neighbourhood officers, who cheerily maintain order. And sometimes they wield their truncheons with punishing effect' (Billig 2005:238).

Miller arrived at the intersections of laughter and embarrassment by studying embarrassment; in his studies embarrassing situations were often referred to as funny. However, when an individual experience embarrassment it is not always accompanied by laughter (Miller 1996). A potentially embarrassing incident not observed by anyone, may be evaded and soon forgotten. Other incidents can be remedied without attracting particular attention or made comic, and soon forgotten. The third group of embarrassing incidents elicits laughter – where the unhappy individual most often joins in and laughs at herself. Miller contends that we seldom feel embarrassed when alone; we are most embarrassed when in front of strangers or acquaintances; and experience embarrassment to a lesser degree within family and friends circles. The intensity of the experiences depends on the situation at large. We embarrass by way of individual behaviour, interactive behaviour, audience provocation, and bystander behaviour (Miller 1996:51-69).

Laughter

As stated in the methods literature on focus groups research, the hall mark of focus groups is interaction, and ideally participants and researchers cooperate to sustain a situational definition. However, interruptions, laughter, jokes, badinage and cryptic comments from the participants may cut across and over the research agenda (Gouin 2004; Wanzer, Booth-Butterfield, & Booth-Butterfield 2005; Wilkinson, Rees, & Knight 2007). As have been seen in the extracts, interruptions and laughter flourished. Jokes, badinage and cryptic comments were also present. In their study of user involvement in medical education, Wilkinson et al. conducted focus groups to gather the views of medical educators, students and service users who had participated in medical education in the past (Wilkinson, Rees, & Knight 2007). The first publication from their project, interestingly, was an article addressing the participants' use of humor in the focus groups. The authors argue that the use of humor is one area of interaction and negotiation that is methodologically interesting and theoretically insightful. I concur, but for other reasons. Their argument is built on 'ideological positivism' (Billig 2005), where laughter is construed as an attractive good, and where the negatives of humour

are ignored – the issue of ridicule. When laughter is indicated in their excerpts, however, someone is laughed at or ridiculed.

To Billig, laughter is rhetoric and a part of our language. Language is dialectic, and every utterance or word can be countered or denied. The denial of laughter is unlaughter – to refuse to laugh when expected; e.g. as ear-splitting silence after an utterance or performance where laughter was expected. The notion of rebellious humour conveys an image of momentary freedom from the restraints of social convention. This is a difficult task – apparent rebellion may reinforce social structure, because it is dependent on the structure it mocks (Billig 2005:212). This illustrates Douglas argument that jokes are only possible when and where they are structurally present (Douglas 1968). Disabled stand-up comedians are struggling with these challenges daily (Reid, Stoughton, & Smith 2006), as are others who try to rebel, revert or change social order.

It is beyond the scope of this study to give a comprehensive analysis of laughter, and its cousin humour, in research groups or elsewhere. Following Goffman's lead, and Billig's extension of his arguments, I will tease out their suggestions that the key to understanding laughter is to understand reproduction of social interaction and social order. Ridicule and embarrassment are social glue mediated by laughter, an argument supported by Fine & Soucey as well (Fine & Soucey 2005). Where there is laughter, there's a structural joke, a social false note, a discord or a disruption which must be repressed, disciplined or amended – or as it became in this study, an issue in need of analysis. Accordingly, understanding laughter, ridicule or humour necessitates an understanding of social reproduction and seriousness (Billig 2005;Douglas 1968;Goffman 1956;Miller 1996;Mulkey 1988).

The outline of this thesis gradually configured as I took closer looks into situations where laughter abounded. The participants more often than not laughed about the absence or distorted phenomenon of interest; missing or obscured dialogue and touch, care taken of self presentation to avoid misunderstandings, gendered disturbance and intersections, and illegitimate pain. They also laughed when they discussed their different doings; how they tried to use their resources strategically to enhance the possibilities for making a therapeutic encounter come off, or increase their sense of health and well-being.

The incidents of *laughter* in the transcript were counted. A rewriting of the transcript, paying more attention to laughter and laughter particles, would probably have increased these numbers. Still, there were 45-65 notations of laughter in all groups, save the male C-group, where only 20 incidents were noted. Interestingly, most of the laughter in the male C-group was located in the start and the end of the session, concerning issues outside the topic for discussion. The next subsection presents some exemplars from the present study with respect to laughter and embarrassment, and laughing at the situation at large.

Social mishaps, sticky or tricky situations, and structural jokes

Embarrassment is acknowledged as a master emotion, however, scholars do not agree upon how to classify embarrassing situations or triggering factors. Social mishaps, gaffes or *faux pas* are the small disruption of everyday living; forgetting to button one's trousers, an open fly, the wrong clothes, forgetting of names, or worrying about cleanliness (Goffman 1956; Sabini et al. 2000). The animated discussions of black bras fall into this category, as do the bewilderment of some members of the male C-group when they thought they volunteered to participate in a massage class, not a focus group. Both these occasions elicited huge amounts of laughter. The story about the man falling from a ladder when painting and his wife's attempts at rearranging him before he had to go to the hospital is a classic faux gaffe. Bodily eruptions as speaking too loud, laughing too loud or at the wrong time, or farting are regular social mishaps that may cause embarrassment. In physiotherapy complaining too much about pain may be interpreted as bodily eruptions. Carmen's comment 'injury due to overload is embarrassing' is a gaffe.

Sticky situations (Sabini, Siepmann, Stein, & Meyerowitz 2000:215-16) refer to situations in which one must do something which will discredit the performance of someone else in the interaction, or refer to situations where things turn out wrongly. The case of PhX clearly falls into this picture, and Alexandra is deeply embarrassed by the incident. Two examples given in the male C-group are sticky as well – being left alone in a cubicle with some machinery that goes wrong and gives the patient electrical shock, and another situation of being forgotten and left behind in a cubicle. These situations all discredit the performance of the therapists, but the patients may feel deeply embarrassed.

Tricky situations (Billig 2005;Goffman 1956) refer to the embarrassment that is felt when participants find themselves in situation where there is a conflict of expectations, i.e. for interaction between patient and therapist. The case of PhX fall into this category as well, as do the broken communication situation between some of the A-ladies and their physicians, the B-gentlemen's deliberation of what to tell their wives and what to tell their physicians, i.e. when the one not physically present are felt as present. Britney's comment is pithy: ... being embarrassed on the thought of creating a misunderstanding. The case of sports related injuries, pain signals during matches and wearing props are also tricky situations. The short moment of bewilderment and confusion in the male C-group may fall into this category as well. The men of C-group refer to being treated by a girl their age, and refer to an imagined scenario where they were half drunk and I was permitted to participate in changing room-joshing, represents tricky situations. Living with chronic pain or medically unexplained disorders are obviously tricky situations where embarrassment may be evoked. Embarrassment may be painful for the one who is embarrassed, but it is frequently funny to onlooker. Tricky situations provide the subject matter for comedies (Billig 2005:222)

Structural jokes (Douglas 1968;Mulkay 1988) are built into the situation, and are not dependent on the individuals' actions. These jokes can be evoked, but not created, independent of structure. Cassandra's exemplar referred to the impossibility of differentiating people in white clothes at the hospital, she didn't know if she had met a dozen physiotherapists or none during her stay, and everybody laughed. Britney's comment about the lack of interest in touching old bodies, and that she takes anything that may help, also refers to structural factors, not her as a person. Bernhard's telling about a Dane physiotherapist who left in the middle of a treatment session, and Desmond's personal ad test, the time spent on sounding each other out, refer to structural possibilities for joking. The same goes for the group of D-men's teasing of David's fragrance when attending female therapists his age. The A-ladies ridiculing of medical diagnosis hierarchies (c.f. fibromyalgia) may be interpreted as a structural joke as well.

Unwanted exposure of self (Robbins & Parlavecchio 2006) may also cause embarrassment. The women of D-group laughed the loudest, and they gave plenty of evidence for unwanted exposure of self. This also holds true for the A and B groups, and the male D-group, where we fell into laughter recurrently. The multiple stories on pain communication, of presenting

one self as a credible patient, or being unable to keep up male duties exposed the selves to their therapist or physicians.

Being the centre of attention (Sabini, Siepmann, Stein, & Meyerowitz 2000) may also cause embarrassment, but of another kind. Bernhard's detailed story from receiving Thai massage certainly fits this category. My study suggests that not being the centre of the therapist attention is experienced as problematic, whereas Sabini et al. suggest that this attention may be embarrassing. This kind of embarrassment might add to the kinds of embarrassment described above; however, this is an ambiguous assumption.

Miller (1996) divides embarrassing situations into two broad categories: disruption of social interaction (e.g. *faux pas*, gaffe) or social evaluation (loss of self-esteem). Events disrupting social interaction are described above, whereas loss of self-esteem may be a result of the embarrassing situations described. Loss of self-esteem is detrimental to a therapeutic encounter whether this is the primordial cause or a secondary effect of social disruption.

As Miller (1996) stated, we are more embarrassed amongst strangers and acquaintances than within friends or family circles. Further, we are at risk to become embarrassed if there is a conflict of expectations in the social setting, or things are turning out wrongly. Evasion, remedy, laughter, or withdrawals are means at hand to the interactants. The men of C-group did not produce much laughter during their discussion of the subject matter of the focus group, but laughed heartily at the beginning and ending of the group (misunderstanding of the focus group and joshing in the changing room). The lack of laughter may be an indication of evasion, of a friendly relationship to their therapists or of few confounding factors or contradictory expectations (gender, age, diagnosis, recommended treatment). This is only a suggestion which gives reason for fewer opportunities or need for falling into laughter during the group discussion.

According to Billig, the 'laugh about it later' story recalls something important about social life (2005:223). When the participants have told about past experiences, the 'laugh about it later' stories now belong to the teller and their hearers. As such, the stories told are stories about how the teller disrupted the social interaction. The stories might be understood as a mean of coping with painful and embarrassing experiences or memories, by transforming the pain of the past to the pleasure of the present. In this study the focus groups are the audience

which validates and justifies this transaction. But more important, Billig argues, the shared laughter indicates the pleasure of disrupting social order whose power was painfully felt at the time. Hearers might laugh with delight at the idea of making a bad impression, subverting the normal behaviour expected. Billig summarises the case of laughter to indicate pleasure of subversion and revenge at the ridicule of embarrassment (Billig 2005:222-4). Social life necessitates compliance and empathy, but at the same time they engender pleasure of ridicule and disruption and voluntary risk taking (Billig 2005;Lupton 1999;Lyng 2005;Tulloch & Lupton 2003).

Closing remarks

This chapter teased out the argument that social reproduction is engendered by social participants' fear of embarrassment and shame. When a sticky or tricky situation emerges, laughter may erupt in the situation, or later, when the story is retold. Laughter in focus groups may be interpreted as a sign of embarrassment due to fragile interaction or structural jokes. Physiotherapy, and other health care agencies, represents a field of practices where contradictory and covert social expectations reside, and where few body idioms or interpretive schemes are commonly at hand to interpret and guide physically proximate interaction. Embarrassment or shame, the emotional response to unfulfilled social expectations, puts an interaction to a halt, and remedies are warranted. Encounters may continue to be in play if embarrassing situations are ignored, remedied or laughed at. When neither of these actions are able to sustain a definition of the situation, or make an encounter come off a new, the spell of playful interaction may be broken. Embarrassment is a more or less painful social experience, but may become a laughable story when retold to a selected audience later. 'To talk with jest about one's wounds' is a phrase borrowed from Bernhard, which the participants in this study have demonstrated they do.

Goffman suggested that by studying embarrassment the sociologist can listen for social dissonance, and imply the conditions necessary for the interaction to go right (Goffman 1967:112 n10). Some necessary conditions are implied as agency, as engendering body politics. However, the question of embarrassment in physiotherapy, or in other health and social services, is a call for more studies (Harris 2003).

The next chapter is closing the thesis, presenting the main argument drawn from this study, and points towards some issues for further inquiries.

12. Final remarks

The ontological premise of this study states any human being as intentional. In this thesis, intentional expressions are described as agency; as the condition of being in action building on understanding of the situation at hand. The social scientist's task is to reconstruct agency, i.e. making agency in specific contexts intelligible to a wider audience. According to Gadamer, interpretation is a game⁴² in which one has to go along with the meanings in which one participates (Gadamer & Grondin 2006:375). The participants in this study comply with and subvert the meanings in which they participate. They use and borrow social expectations and actions across the 'meaning in which they participate'; e.g. social expectations and recommendations regarding gendered conduct, the sick role, construction of health or recuperative physiotherapy are put differently together to meet different aims.

Outline of the argument

According to the participants in this study, the prerequisites for a recuperative physiotherapy which aims at facilitating bodily changes and well-being encompass verbal, bodily and hands-on dialogues, and an attentive physically present therapist. The dialogical situation is precariously constructed; self presentation is planned to details and carefully enacted– e.g. cleanliness, clothing, gendered conduct, communication on impairments and pain and everyday living. In this study gender is construed as a social institution and as agency, which accords for how gender imprints interaction, understanding and treatment. Further, pain is construed as action, and a paradigmatic exemplar of how verbal, bodily and hands-on communication, self presentation and gender intersect in physiotherapy. Independent of age, gender or bodily concerns the participants give accounts of how they challenge cultural, medical or personal boundaries to enhance well-being and/or to reach personal objectives. Their accounts justifies how and why they can enjoy the benefits of voluntary risk taking; e.g. allocating personal resources, increasing pain for a greater good or flouting health related advices risking exacerbation. In the present study such accounts are interpreted as intentional

⁴² C.f. chapter three on 'Play as creative dialects': "In German the word *Spiel* means both play and game. Our translation will sometimes use one term, sometimes the other, depending on the context, and sometimes also "playing the game", in order to suggest the overtones of motion" (Gadamer 2007:434 n29). Billig uses the game-metaphor in a Gadamerian understanding as "conversation as a game" and in a Goffmanian understanding as "life as a game" (Billig 1996:47-56), both having a bearing for the present study. Tanya diTommaso settles on play-game, to capture the dialectical movement involved in understanding (DiTommaso 1996).

human agency, which are reconstructed as body politics. Drawing on a construction of vulnerability as strength, the participants in this study are appreciating some of the benefits gained from their everyday life with diverse bodily constraints and challenges, in which physiotherapy is included on irregular or regular basis. Their actions and enactments create new body idioms and accounts of health/illness, which subsequently may contribute to incremental changes in social institutions by keeping them rife with conflicts and multiplicity.

The argument above suggests an answer to the question: *What do patients do to negotiate enabling and constraining aspects of recuperative physiotherapy?* However, this answer prompts a new question: *Why do they need such a precariously engendered body politics?* Physiotherapy represents a field of practices where contradictory and covert social expectations reside. When social expectations in the therapeutic encounter are not met – e.g. due to social mishaps or the situation embeds contradictory expectations or things are turning out wrongly – patients may experience embarrassment, and recuperative interaction may be at risk. The argument that follows resides with the idea that everyday codes of behaviour are protected by the practice of embarrassment. If one infringes expected codes of interaction, particularly if one does so unwittingly, one might expect to be embarrassed. What is embarrassing for the actor is often comic to onlookers, invoking laughter. Social actors fear this laughter and its ridiculing aspect. Accordingly, the prospect of ridicule and embarrassment protects codes of daily behaviour and situational propriety, ensuring much routine conformity with social order.

Social disruptions independent of origin may be ignored or remedied, and soon forgotten. When evasion or remedy is impossible, laughter may be the last recourse. The participants in the present study recurrently fell into laughter, laughing at diverse disruption in therapy sessions, disruption of communication, personal resource allocation and so forth. Laughter in focus groups, or more precisely laughing at past experiences retold as amusing stories in focus groups, may be interpreted as a sign of embarrassment and social reproduction – and hence a possible constraint upon agency and recuperative physiotherapy. Several scholars suggest that the key to understanding laughter is to understand reproduction of social interaction and social order. The core of the argument is that ridicule and embarrassment are social glues mediated by laughter. By studying embarrassment and laughter we can listen for

social dissonance, and make attempts at implying the conditions necessary for the interaction to go right. Some necessary conditions are implied above; i.e. by engendering a personal body politics the participants, as patients, try to avoid embarrassing situations by asserting a personal body politics and warranting amendments to the interaction order of therapeutic encounters.

New openings

As touched upon above, the issue of embarrassment and laughter warrants further studies. We do not know much about where the professionals sit in the process of contributing to creating embarrassment as a form of social control in therapy. We need more knowledge to develop awareness of how we use and misuse laughter and embarrassment. A methodological aspect not to be forgotten is to take a closer look at how we relate to the challenge of researching an embarrassing topic, or embarrassment in general, when both the participants and the researcher could be embarrassed by discussing embarrassment. Lastly, we need to take a closer look at the prerequisites and possibilities for physiotherapists (or any health care professional) to be trained to read the signals of embarrassment, and how they can be used to promote a more recuperative interaction.

A second matter which warrants further studies is the issue of voluntary risk taking or edgework, illustrated in this study by practices related to pain. Comparative studies where pushing bodily boundaries with drugs, speeding, climbing, athletics, theatre sports, disability, or extreme sports may reveal accomplishments and strategies across the different undertakings. Knowledge gained from such studies may be fed back to health and social care agencies and purport incremental but significant changes in the interaction order between users and providers, as well as offered as amendments to the social institutions of health and gender.

A third issue; accounts of health and illness related to recuperation abroad and health tourism were aired several times by the participants in the present study. As a rule of thumb they were all given higher marks than comparative therapy at home. Comparative studies are warranted. Further, the issue of personal medicine (Deegan 2005) as participating in pool therapy/swimming circles, folk dance, leisure activities, alternative medicine/remedies, or

other recurrent routines of daily living that enhances well-being may help to edit or amend the interpretive background (medical knowledge, body idioms, health displays) which resides in health and social care agencies. The case of recuperation abroad and personal medicine may benefit from a comparative perspective. The stories told in the research groups give reason to believe that the particular sense of community created abroad or in local initiatives facilitate self-healing potentials and offer a number of paths to well-being.

A last, but not less important suggestion has to be made. The present study has coined play as a pivotal concept and accomplishment. Further studies are warranted to illuminate the intersection between the hermeneutics of play in physiotherapy and the locally situated interaction order. As suggested above, embarrassment is a key issue. However, we can explore and exploit embarrassment and ridicule from the humorous corner, i.e. inquire into the social glue. Then we may learn more about how to make things happen, and promote change and well-being (Johnstone 1999;Johnstone 2007). After all, that is why patients seek physiotherapy in the first place.

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List of appendices

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Ethical Approval and Privacy Protection

The study ‘Doing Gender in Physiotherapy’ is reviewed in accordance with the Helsinki Declaration of 1975, as revised in 1983. The study is approved by the Regional Committees for Medical Research Ethics, Western Norway, REK West, 7 March 2003, journal no 126/03-170.02.

The study ‘Doing Gender in Physiotherapy’ is approved by the Norwegian Social Science Data Services, NSD, ombudsman for privacy protection, 27 February 2003, journal no 200200889 LT/RH.

Forespørsel om å delta i forskningsprosjektet

”Hvordan gjøres kjønn i fysioterapi – sett fra brukersiden?”

Dette er en forespørsel om å delta i et forskningsprosjekt om fysioterapi. Målet med prosjektet er å få innsikt i hvordan fysioterapi blir til, og særlig hvilken betydning kjønn har i møtet mellom bruker og fysioterapeut. Brukernes erfaringer og synspunkter er hovedkilden for forskningsprosjektet. Prosjektet fokuserer på betydninger og forståelser av forholdet mellom bruker og fysioterapeut, og ikke på spesielle behandlingsmetoder eller tiltak. Jeg skal ikke ha kontakt med den/de fysioterapeuter du som leser dette har hatt, eller har kontakt med. Prosjektet skal føre fram til en samfunnsvitenskapelig doktorgrad. En kort beskrivelse av prosjektet er vedlagt.

Informasjon om praktiske forhold:

Jeg ønsker å samle en gruppe på 5-8 personer, en såkalt fokusgruppe, fra samme forening/ virksomhet/ aktivitet som du tilhører. Gruppen skal møtes en gang, og skal diskutere spørsmål og tema som jeg presenterer. Gruppediskusjonen krever ingen spesielle forberedelser fra deltakernes side. Kvinner og menn er i ulike grupper. Spørsmålene vil dreie seg om forventninger til møtet med fysioterapeuter, og refleksjoner under og etter behandlingen. Jeg er særlig opptatt av hvilke betydninger partenes kjønn har for forventninger, utforming og opplevelse av behandlingen. Jeg kommer ikke til å stille direkte spørsmål omkring sykdom, funksjonsvansker eller spesifikk fysioterapibehandling, eller om fysioterapeuten(e) dere har kontakt med, eller har vært hos tidligere.

Fokusgruppen finner sted på et tidspunkt og sted som passer deltakerne. Den maksimale tidsrammen er 2,5 time, inkludert tid til å hilse på hverandre, litt uformell prat, signere samtykkeerklæring og selve gruppediskusjonen. Det vil bli lett servering. Deltakelse honoreres ikke, men utgifter i forbindelse med deltakelse vil bli refundert.

Avtale om deltakelse

Dersom du har anledning og lyst til å delta i dette prosjektet, kan du gi beskjed til den som har formidlet dette skrevet, eller kontakte meg direkte (se under). Jeg vil så ta direkte kontakt med deg for å avtale tid og sted for gruppeintervju. Til orientering har jeg vedlagt kopi av samtykkeerklæring, se neste side. Signering foretas når vi møtes, før gruppeintervjuet begynner.

Prosjektansvarlig

Jeg er utdannet fysioterapeut og samfunnsviter, og er nå stipendiat ved Fysioterapeututdanningen, Avdeling for helse- og sosialfag, Høgskolen i Bergen. Prosjektleder Tobba (Torbjørg) Sudmann kan kontaktes på:
Fysioterapeututdanningen, Høgskolen i Bergen, Møllendalsveien 6, 5009 Bergen
Telefon 55 58 56 75 (kontor), mobil 90 06 14 69, e-post tsu@hib.no.

Prosjektets veiledere er førsteamanuensene Målfrid Råheim og Astrid Blystad, Institutt for samfunnsmedisinske fag, Universitetet i Bergen., telefon 55 58 61 00 (ekspedisjon).

Til orientering:

Informert samtykke til deltaking i forskningsprosjekt/fokusgruppe

Jeg har fått skriftlig og muntlig informasjon om T. Sudmanns doktorgradsarbeid ”Hvordan gjøres kjønn i fysioterapi – sett fra brukersiden?”, og sier meg villig til å delta i en fokusgruppe/gruppediskusjon. Jeg er informert om at deltakelse er frivillig, og at jeg kan trekke meg på et hvert tidspunkt uten begrunnelse. Jeg er informert om at deltakelse ikke følges av særskilt godtgjørelse.

Intervjuet vil bli tatt opp på lydbånd/minidisk, og skrevet ut av T. Sudmann. Utskrifter, notater og lydbånd vil bli oppbevart på et sikkert sted. Lydbåndene blir slettet, og notater makulert når arbeidet er avsluttet. Fullt navn, fødselsdato, adresse, diagnoser eller lignende skal ikke registreres på lydbånd.

Alle deltakere i prosjektet skal sikres full anonymitet, iht. konsesjonsvilkårene for prosjektet. Prosjektet er fremlagt for Regional komité for medisinsk forskningsetikk, Vest-Norge, REK-Vest, og meldt til Datafaglig sekretariat, Norsk samfunnsvitenskapelig datatjeneste NSD. Opplysninger som framkommer i intervjuene er ikke tilgjengelige for andre enn prosjektleder før de er bearbeidet, anonymisert og publisert. Dersom anonymisering ikke er mulig, skal dataene ikke brukes.

Prosjektets veiledere er førsteamanuensene Målfrid Råheim og Astrid Blystad, Institutt for samfunnsmedisinske fag, Universitetet i Bergen, telefon 55 58 61 00 (ekspedisjon)

Prosjektleder Tobba Torbjørg Therkildsen Sudmann kan kontaktes på:
Institutt for helse- og sosialforskning, Høgskolen i Bergen, Haugeveien 28, 5005 Bergen
Telefon 55 58 56 75 (kontor), mobil 90 06 14 69, e-post tsu@hib.no.

Samtykkeerklæringen underskrives i 2 eksemplarer – ett til deltaker og ett til prosjektleder.

Sted/dato:.....

Deltaker:.....

Prosjektleder:.....

Adresse/ telefon/ e-post:.....

Med vennlig hilsen
Tobba Therkildsen Sudmann

Bergen

HVORDAN GJØRES KJØNN I FYSIOTERAPI – SETT FRA BRUKERSIDEN?

Målsetting:

Fysioterapi *skapes* av bruker/pasient⁴³ og fysioterapeut *sammen*. Målet med prosjektet er å få innsikt i hvordan fysioterapi blir til, og særlig hvilken betydning kjønn har i møtet mellom bruker og fysioterapeut. Brukernes erfaringer og synspunkter er fokus i undersøkelsen. Kjønn kan sees både som noe mer og noe annet enn å være mann eller kvinne. Dette *noe* preger både språk, steder, ting, aktiviteter og handlinger, og utgjør en del av rammene for et hvert møte mellom mennesker – som for eksempel et behandlingsmøte. Å *gjøre kjønn* i fysioterapi omfatter blant annet hvordan en tenker omkring erfaringer fra fysioterapi, hvordan en forbereder seg på forhånd, hva en opplever, erfarer eller tenker mens en er sammen med fysioterapeuten. Å *gjøre kjønn* handler også om valg av klær, av- eller påkledning, berøring, behag og ubehag, kroppens utseende og fason, fysioterapeutens forventninger til brukerne, osv. Å forske på ”å gjøre kjønn” kan oversettes med å utforske hvordan det er mulig eller umulig å snakke om og reflektere over kjønn i fysioterapi, og utforske assosiasjoner knyttet til temaet. Prosjektet skal føre fram til en samfunnsvitenskapelig doktorgrad.

Forskningsspørsmål:

1. Hvordan erfarer og forholder pasient/bruker seg til de sosiale og kulturelle krav til kroppslig og sosial framstilling av seg selv i møte med fysioterapeuten?
2. Hvordan erfarer og forholder pasient/bruker seg til de sosiale og kulturelle forventninger til fysioterapeutens kroppslige og sosiale framstilling av seg selv?
3. Hvordan vil de gjensidige sosiokulturelle krav og forventninger påvirke det fysioterapifaglige og mellommenneskelige innholdet i relasjonen?
4. Hvordan gjøres og erfares det konkrete kroppslige samspillet?
5. Kan kunnskap fra brukernes erfaringer peke på noen mønstre, nødvendige betingelser eller begrensninger knyttet til kjønn, for å konstituere og vedlikeholde gode terapeutiske relasjoner?

Bakgrunn

Fysioterapeuter prøver på ulike måter å skape ”nøytrale” behandlingsforhold til sine pasienter/brukere. Forskjellen på menn og kvinner, unge og eldre, akademikere og håndverkere, eller forskjeller knyttet til sykdom, funksjon eller etnisitet skal ikke påvirke forholdet mellom fysioterapeuten og pasienten/brukeren, slik at behandlingen ikke følger prinsipper for god faglig virksomhet. Dette idealet er ikke alltid like lett å arbeide etter. Jeg har i tidligere arbeider funnet at når fysioterapeutene ble slitne, eller pasientens adferd ble seksualisert eller lite tiltalende på andre måter, ble behandlingen omgjort, omdefinert eller avsluttet. Utfordringene var større dess likere pasient og terapeut var i alder, og dess større avstanden var i felles sosial og kulturell bakgrunn.

⁴³ I gjeldende offentlige strategidokumenter og nyere forskning omkring forholdet mellom tjenesteytere og tjenestemottakere på rehabiliteringsfeltet, er det argumentert for at begrepet pasient skal erstattes av begrepet bruker. I dette prosjektet vil både begrepet bruker og pasient bli brukt. Prosjektet het tidligere ”Pasientens stemme – kilden til å (s)kjøne mer”.

For å forstå hvordan fysioterapi gjøres, er det ikke tilstrekkelig med kunnskap fra bare fysioterapeutenes side. Utforskning av pasienter/brukeres erfaring med fysioterapi er nødvendig for å få mer kunnskap om hvordan fysioterapi blir til, og for å få kunnskap om hvilke praktiske, symbolske eller kroppslige strategier de bruker i forhandlinger om hvordan fysioterapi skapes for dem, og om behandlingen blir avbrutt eller omgjort på grunn av sosial eller kulturell "forstyrrelse".

Metode - deltakere

Forsknings spørsmålene skal belyses ved hjelp av materiale fra fokusgrupper. Fokusgruppene baserer seg på det alminnelige sosiale samspillet, der samtaler og diskusjoner i gruppen gir muligheter til å skape flere assosiasjoner til og beskrivelser av et gitt tema enn enkeltintervjuer kan gjøre. Jeg ønsker 8 grupper (4 med menn, 4 med kvinner) med ca 6 deltakere i hver gruppe i tillegg til gruppelederne. Deltakerne vil bli rekruttert fra 4 typiske områder for fysioterapitjenester. Alle skal være over 18 år, kunne samtykke til deltakelse på egne vegne, og snakke norsk. Deltakerne skal rekrutteres fra eksisterende sosiale grupper som pasientforeninger eller idrettslag. Kontakt skjer gjennom en utvalgt person i gruppen. Deltakerne skal ha erfaring fra en av områdene toppidrett, hjerte-/lungesyke, unge funksjonshemmede / ryggmargsskadede eller revmatikere (inkludert bestemte og ubestemte plager). Jeg skal ha med meg en medarbeider til hver gruppe, en mann til de mannlige gruppene og vice versa. Dette er menn og kvinner som har deltatt i kunnskapsutviklingsprosjektet "Kjønn og rehabilitering" ved Stein Rokkan senter for flerfaglig samfunnsforskning ved Universitetet i Bergen i perioden 2001-03.

Forskningsetisk godkjenning

Prosjektet følger Helsinkideklarasjonens prinsipper og generelle retningslinjer for forskningsetikk. Informert samtykke vil innhentes skriftlig før datainnsamling. Prosjektet er framlagt for Regional komité for medisinsk forskningsetikk, Vest-Norge, og meldt til Datatilsynet i henhold til regelverket. Prosjektet representerer ikke særskilte etiske dilemmaer som krever egen strategi.

Framdriftsplan

Stipendperioden varer fra høsten 2002 og ut 2005. Datainnsamling skal starte opp våren 2003. Prosjektet skal være avsluttet innen utgangen av 2006.

Veiledning

Veiledere for prosjektet er førsteamanuensis Målfrid Råheim (fysioterapeut, dr. philos.) og førsteamanuensis Astrid Blystad (sykepleier, antropolog, dr. polit.), begge Institutt for samfunnsmedisinske fag, Universitetet i Bergen.

Publisering

Prosjektet skal publiseres som en artikkelsamling til samfunnsvitenskapelig doktorgrad. Populærvitenskapelig formidling vil skje gjennom tidsskrifter, kronikker i dagspressen eller fagtidsskrifter, eller presentasjoner i pasientforeninger eller lignende. Formidlingsspråket blir hovedsakelig norsk.

Statutes regulating authorized physiotherapy practice

The following statutes are in force:

Act of 2nd July 1999, no 64 relating to health personnel etc. [The Health Personnel Act].
Physiotherapist can admit patients for assessment and treatment without referral from physicians.

Act of 28th February 1997, no 19, relating to national insurance [National Insurance Act]. This act legally establishes that only physiotherapists, who have a bilateral agreement with municipal authorities, have a right to funding and refusal from the National Insurance.

Act of 19th November 1982, no 62, relating to the municipal health services [Municipal Health Services Act]. This act legally establishes physiotherapy as an obligatory part of the municipal health service system.

Repealed statutes:

Act of 13th July 1956 relating to medical gymnasts and the right to practice medical gymnastics and massage [Medical Gymnasts Act] was repealed 1.1.2004, c.f. The Health Personnel Act.

Act of 19th July 1936 relating to medical gymnasts and masseurs [Medical Gymnasts Act] was repealed when the Medical Gymnast Act of 1956 was in force.

Description of physiotherapy – NPA

Retrieved from <http://www.fysio.no/index.php/Norwegian-Physiotherapist-Association>
09.11.2007

Contact information

Norsk Fysioterapeutforbund
(Norwegian Physiotherapist Association)
P. O. B. 2704 St. Hanshaugen
0131 Oslo, NORWAY

Phone: +47 22 93 30 50

Fax: +47 22 56 58 25

nff@fysio.no

www.fysio.no

Norwegian Physiotherapist Association (NPA) has 8535 members. It organises publicly certified physiotherapists and students. Both private practitioners and publicly employed physiotherapists are members. 77 % of the members are women. The main task of the NPA is working to improve member salaries and working conditions as well as stimulating professional development and quality. The association has 21 local branches. NPA is a member of the World Confederation for Physical Therapy (WCPT).

NPA arranges on average 50 continuing education courses annually. The association publishes the journal Fysioterapeuten (The Physiotherapist) with 14 issues a year.

Specialists

600 NPA members are specialists within one of the following areas:

- General physiotherapy
- Paediatric physiotherapy
- Health and environmental work
- Athletic physiotherapy
- Manual therapy
- Psychiatric and psychosomatic physiotherapy
- Oncological physiotherapy
- Rehabilitation (with six different areas of specialisation)
- Special Interest Groups

NPA has 11 Special Interest Groups. Members can join one or several of the fields.

- Paediatric and juvenile physiotherapy
- Ergonomics
- Gerontology/geriatric physiotherapy
- Manual therapy

- Mensendieck physiotherapy
- Neurology/orthopaedics/rheumatology
- Women's health
- Psychiatric and psychosomatic physiotherapy
- Athletic physiotherapy
- Cardio pulmonary physiotherapy
- Oncological physiotherapy

Physiotherapy in Norway

In Norway physiotherapy is protected by law. Norwegian citizens are entitled to get treatment from a physiotherapist if they need it. Both title and functions are legally defined. The physiotherapist is legally responsible for his or her own professional actions.

Physiotherapy constitutes prevention and treatment of disease and physical suffering. The physiotherapist has extensive knowledge of the parts of the body we use when we move i.e. muscles, tendons, joints, the circulatory system, and respiration. The main tasks of a physiotherapist are health promotion and disease prevention, treatment, training, and rehabilitation.

Health promotion and disease prevention

The physiotherapist knows why disease and injury occur, and can give advice on how to prevent pain and relapse of disease. The physiotherapist's work in health clinics, in nurseries, at schools and in work places is mainly preventive. A sub speciality within physiotherapy is ergonomics, which involves organising work environment. Many companies have their own physiotherapist who gives advice on how to promote health and to improve the environment and safety in the work place.

Treatment

First the physiotherapist performs a thorough examination; the type of treatment given depends on the patient's resources and the connection between pain, joint mobilisation and muscle tension. Training, exercise, massage, hot and cold treatment, or electrotherapy are among the types of treatment that can be given. The treatment is given either individually or in groups.

Many Norwegian physiotherapists have postgraduate training. The most common fields are manual therapy and psychiatric and psychosomatic physiotherapy. Physiotherapists who have been trained in manual therapy have special competence on neck, back and pelvic disorders. Following a thorough evaluation, the main elements in the treatment approach are patient guidance, joint manipulation or mobilization, and exercise therapy. Psychiatric and psychosomatic physiotherapy aims at easing physical tension, improving respiration, or body awareness. This kind of treatment is not only aimed at treating local symptoms, but is a continuous treatment. Many physiotherapist offer group treatment in psychiatric and psychosomatic physiotherapy.

Habilitation

The training of children with congenital dysfunction to a best possible level of functionality is

called habilitation. This is interdisciplinary work where the physiotherapist is part of a habilitation team. Such teams are found in every region of the country. Habilitation takes place in the counties, at the hospitals and in special institutions.

Rehabilitation

Rehabilitation is aimed at helping persons with handicaps or chronic disease so they can manage on their own and function socially. The aim of this process is for the patient to regain or preserve a best possible level of functionality through learning and by using own resources. The term rehabilitation is used about the work with patients from 16-18 years of age to the end of life. The patients may have been subject to accidents or disease. One such disease may be stroke, which is an example of a disease that demands interdisciplinary co-operation. Physiotherapists work with rehabilitation in the patient's home, in nursing homes, and in special institutions.

Where do Norwegian physiotherapists work?

The work of physiotherapists involves all parts of health care and the working life in general. The local communities are legally obliged to provide physiotherapy to its citizens. Among the members of the Norwegian Physiotherapist Association (NPA), there are 2,300 private practitioners and around 2,800 who are public employees (employed by the counties, regions, and state). A third category work in private companies, i.e. ergonomics. This applies to 500 of NPA's members.

Private practice

There are two types of physiotherapists with private practice in Norway: Those with and those without an agreement with the local county or community. Those who have an agreement with the community receive an annual contribution. (This is a fixed rate, in 2001 it is NOK 182.520). The local social security office also reimburses them. These physiotherapists operate with prices that are set by the "Price agreement". The other category of private practitioner operates without an agreement with the local community. They do not receive any contributions and are not reimbursed by the local social security office. They compensate by charging their patients more.

Public activity

In excess of 1,000 NPA members work in hospitals. Among the most important tasks they perform are mobility training after surgery, breathing exercises, pain therapy, and relaxation. Many physiotherapists are employed in health institutions (such as psychiatric institutions), or at rehabilitation centres. The different counties employ 1,500 of NAP's members. They work in health centres, in nurseries, in schools, and in the patient's homes. Physiotherapists also work in the fields of education, research and administration.

Education

In order to become a physiotherapist in Norway you need to study for three years in an institution of higher education, and also have one year of mandatory practise. Around 300 physiotherapists are educated in Norway each year. Traditionally, many Norwegians have studied physiotherapy abroad. Most of the students have gone to Denmark, Great Britain, Germany, the Netherlands and the US. This trend is going to change from 2001, because the government has decided to withdraw grants to students who wish to study physiotherapy abroad.

There are five centres for educating physiotherapists in Norway:

Oslo College, School of Health

Department of Physiotherapy

Phone: +47 22 45 24 00

Oslo College, School of Health

Department of Mensendieck

Phone: +47 22 45 24 30

Sør-Trøndelag College, School of Health Education and Social Work

Department of Physiotherapy

Phone: +47 73 55 91 50

Bergen College, School of Health and Functionality

Department of Physiotherapy

Phone: +47 55 58 75 00

Tromsø College

Department of Physiotherapy

Phone: +47 77 66 06 01

Description of Physical Therapy –WCPT

Retrieved from www.wcpt.org , 29 Mars 2006

Position Statement World Confederation for Physical Therapy WCPT

In response to a motion at the 13th General Meeting to develop a description of physical therapy, WCPT initiated a consultative exercise with the intention of providing a foundation on which Member Organizations in different parts of the world could build a description of physical therapy relevant to their needs.

WCPT is committed to supporting Member Organizations not stereotyping them. It is in this spirit that this description of physical therapy has been drawn up in response to the expressed need of members. It is intended as a Position Statement rather than a Declaration of Principle and is therefore open to be adopted fully, in part or developed to meet the evolving needs of the profession. New research is proving further evidence upon which future practice will build. Nowhere is this more apparent than in our understanding of human movement which is central to the skills and knowledge of the physical therapist. Clearly the uniqueness of the contribution which physical therapy can make to health care in the next millennium remains to be fully defined. This statement is presented as the basis upon which subsequent reviews of the description will continue to be conducted in response to the development of knowledge in physical therapy and the profession's response to changing health needs of society.

What is Physical Therapy?

The nature of physical therapy

Physical therapy is providing services to people and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. Physical therapy includes the provision of services in circumstances where movement and function are threatened by the process of ageing or that of injury or disease. Full and functional movement is at the heart of what it means to be healthy.

Physical therapy is concerned with identifying and maximizing movement potential, within the spheres of promotion, prevention, treatment and rehabilitation. Physical therapy involves the interaction between physical therapist, patients or clients, families and care givers, in a process of assessing movement potential and in establishing agreed upon goals and objectives using knowledge and skills unique to physical therapists.

The physical therapists' distinctive view of the body and its movement needs and potential is central to determining a disorder and an intervention strategy and is consistent whatever the setting in which practice is undertaken. These settings will vary in relation to whether physical therapy is concerned with health promotion, prevention, treatment or rehabilitation.

The nature of the physical therapy process

Physical therapy is the service only provided by, or under the direction and supervision of a physical therapist and includes assessment, diagnosis, planning, intervention and evaluation.

Assessment includes both the **examination** of individuals or groups with actual or potential impairments, functional limitations, disabilities, or other conditions of health by history taking, screening and the use of specific tests and measures and **evaluation** of the results of the examination through analysis and synthesis within a process of clinical reasoning.

Disorder arises from the examination and evaluation and represents the outcome of the process of clinical reasoning. This may be expressed in terms of movement dysfunction or may encompass categories of impairments, functional limitations, abilities/ disabilities or syndromes.

Planning begins with determination of the need for intervention and normally leads to the development of a plan of intervention, including measurable outcome goals negotiated in collaboration with the patient/ client, family or care giver. Alternatively it may lead to referral to another agency in cases which are inappropriate for physical therapy.

Intervention is implemented and modified in order to reach agreed goals and may include manual handling; movement enhancement; physical, electrotherapeutic and mechanical agents; functional training; provision of aids and appliances; patient related instruction and counseling; documentation and coordination, and communication. Intervention may also be aimed at **prevention** of impairments, functional limitations, disability and injury including the **promotion** and maintenance of health, quality of life, and fitness in all ages and populations.

Evaluation necessitates **reexamination** for the purpose of evaluating outcomes.

Where is physical therapy practised?

The scope of physical therapy services

Physical therapy is an essential part of the health services delivery system. Physical therapists practice independently of other health care providers and also within interdisciplinary rehabilitation/habilitation programs for the restoration of optimal function and quality of life in individuals with loss and disorders of movement. Physical therapists are guided by their own code of ethical principles. Thus, they may be concerned with one of the following purposes:

- **Promoting** the health and well being of the individual and the general public/society.
- **Preventing** impairments, functional limitations, and disabilities in individuals at risk of altered movement behaviours due to health or medically related factors, socioeconomic stressors, and lifestyle factors.
- **Providing interventions** to restore integrity of body systems essential to movement, maximise function and recuperation, minimise incapacity, and enhance the quality of life in individuals and groups of individuals with altered movement behaviours resulting from impairments, functional limitations, disabilities.

Settings in which physical therapy is practised

Physical therapy is delivered in a variety of settings which allow for it to achieve its purpose.

Treatment and **Rehabilitation** usually occur in community and acute care settings which may include but are not confined to the following:

- Hospices

- Hospitals
- Nursing Homes
- Rehabilitation Centres/Residential Homes
- Physical Therapist Private Office/Practice/Clinic
- Out-Patient Clinics
- Community Settings: Primary Health Care Centres: Individual Homes: Field Settings
- Education and Research Centres

Prevention and Health Promotion are more likely to occur in the following settings although they often form an integral part of treatment and rehabilitation offered within other care settings.

- Fitness Centres/Health Clubs/Spas
- Occupational Health Centres
- Schools
- Senior Citizen Centres
- Sports Centres
- Workplace/Companies
- Public settings (i.e. Shopping Malls) for health promotion

What Characterises Physical Therapy?

Assumptions underlying the knowledge and practice of physical therapy

The following assumptions are embedded in this description and reflect the central issues of physical therapy.

Movement

The capacity to move is an essential element of health and wellbeing. Movement is dependent upon the integrated, coordinated function of the human body at a number of different levels.

Movement is purposeful and is affected by internal and external factors.

Physical therapy is directed towards the movement needs and potential of the individual.

Individuals

Individuals have the capacity to change as a result of their responses to physical, psychological, social and environmental factors.

Body, mind and spirit contribute to individuals' views of themselves and enable them to develop an awareness of their own movement needs and goals.

Ethical principles require the physical therapist to recognise the autonomy of the patient or legal guardian in seeking his or her services.

Interaction

Interaction aims to achieve a mutual understanding between the physical therapist and the patient/client/family or care giver and forms an integral part of physical therapy.

Interaction is a prerequisite for a positive change in body awareness and movement behaviours that may promote health and wellbeing.

Interaction often involves partnership within interdisciplinary teams, in determining the needs and formulating goals for physical therapy intervention and recognises the patient/client/family and care givers as being active participants in this process.

Professional Autonomy

Professional education prepares physical therapists to be autonomous practitioners.

Professional autonomy is possible for individual physical therapists as they practice with patients/clients/family and care givers to reach a disorder which will direct their physical therapy interventions.

Disorder

Disorder within physical therapy is the result of a process of clinical reasoning which results in the identification of existing or potential impairments, functional limitations and abilities/disabilities.

The purpose of the disorder is to guide physical therapists in determining the prognosis and identifying the most appropriate intervention strategies for patients/clients and in sharing information with them.

In carrying out the diagnostic process, physical therapists may need to obtain additional information from other professionals.

If the diagnostic process reveals findings that are not within the scope of the physical therapist's knowledge, experience or expertise, the physical therapist will refer the patient/client to another appropriate practitioner.

Where are we now?

Principles supporting the description of physical therapy

In order to make explicit the underlying values upon which this international description of physical therapy is based there follows a list of **principles** which are recognised as important by WCPT.

WCPT believes a description must:

- respect and recognise the history and roots of the profession;
- build on the reality of contemporary practice and the growing body of research;
- allow for variation in: cultures, values and beliefs; health needs of people and societies; and structure of health systems around the world;
- use terminology that is widely understood and adequately defined;
- recognise internationally accepted models and definitions (e.g. World Health Organisation definition of health);
- provide for the ongoing growth and development of the profession and for the identification of the unique contribution of physical therapy;
- acknowledge the importance of the movement sciences within physical therapy curricula at all levels;
- emphasise the need for practice to be evidence based whenever possible;
- appreciate the interdependence of practice, research and education within the profession;
- recognise the need to continuously review the description as the profession changes in response to the health needs of society and the development of knowledge in physical therapy;
- anticipate that work will flow from this description through utilisation of the document to assist in the development of curricula and identification of areas for research.

Acknowledgements:

WCPT acknowledges with appreciation the Member Organisations and individuals who contributed to the Description of physical therapy

Thanks are also due to the authors and publishers of resource material used for reference purposes in this document.

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Tornebohm H(1991): What is worth knowing in Occupational therapy? *American Journal of Occupational Therapy*, Vol.45 No.5 p.451 454

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Approved by the 14th General Meeting of WCPT, May 1999

WCPT, Declaration of Principles and Position Statements, pages 28-31

Co-host, co-researcher and research-assistant

The following persons participated in the Gender Sensitive Rehabilitation project and in this project.

Laila Bøe (F), retired accountant, member of the Norwegian Association of the Disabled, holding several positions of trust, and elected user representative (brukerrepresentant) on diverse health service boards and committees. Laila participated in the Gender Sensitive Rehabilitation project. She organised the A and B groups comprising two male and two female groups, whose members originated from the Norsk Revmatikerforbund and Landsforeningen for hjerte- og lungesyke. Laila brought her personal experience of physiotherapy to bear in the group discussions. Her participation in the discussions is disguised under a pseudonym in the vignettes in this thesis. She participated in the female A and B groups.

Arnhild Taksdal (F), social scientist, research director at the Stein Rokkan Centre for Social Studies, headed the project 'Gender Sensitive Rehabilitation'. She is co-supervisor and tutor on my PhD programme and this thesis. She participated in the female C and D groups.

Asgeir Helle (M), social scientist, Aetat Employment Counsellor for occupationally handicapped,⁴⁴ head of a project initiating labour market initiatives for people with mental health problems. Asgeir participated in the Gender Sensitive Rehabilitation project. He participated in all of the male groups in this study.

Laila, Arnhild and Asgeir have been paid to do this work, since the method is both time consuming and demanding. They also received a bottle of wine and the chocolates given to the other participants in the respective groups.

⁴⁴ Official English translation of the Norwegian term 'yrkeshemmet', according to Aetat in an email of 3 July 2005

Working-paper group 8, D-ladies (in Norwegian)

Ta med:

Minidiskspiller,
minidisk,
sett i nytt batteri,
ark og blyant til alle, visittkort til utdeling,
kaffe,
kaffemelk,
mineralvann,
flaskevann,
frukt,

kjeks,
konfekteske,
servietter,
samtykkeskjema,
info om prosjektet,
gave til deltakerne,
vin til Arnhild og Unni
blå plastmappe,
protokoll,
lønnsskjema til Arnhild,

Hovedmålsetting:

Skape en stemning i rommet slik at alle har det bra, og kan delta i diskusjonen om deltakernes erfaringer med, og refleksjoner om, fysioterapi. Vise og stole på at kunnskapen er i rommet.

Fokusere på ulike betydninger av kjønn, alder og funksjonsevne. Framstår noen forskjeller som mer eller mindre betydningsfulle, i tilfellet i relasjon til hva og hvor

Plukke opp innspill, kommentarer som kan kobles til fysioterapi som voksnes lek; som spill og konkurranse, improvisasjon, utforskning og erkjennelse. Lek som vekslinger mellom nærhet og avstand, mellom impuls og disiplin, mellom kontroll og gi seg hen. Lytte, spørre, utforske deltakernes erfaringer og tanker omkring lekens plass i fysioterapi. Jeg tenker på lek som en grunnleggende måte å være menneske på, og som vi bruker til å forstå og handle (jfr vitenskapsteoretisk essay).

Dagens Leatherman:

Still åpne spørsmål – start spørsmålene med spørreordene hva, hvordan, hvilke, hvorfor, hvem – og be eventuelt om utdypninger etter hvert

Tenk fysioterapi som lek – med bl.a. ulike konstruksjoner av maskuliniteter i spill (se bakerst)

Unge, voksne, funksjonsevne, utdanning, arbeid, bolig, familie (oppvekst, egen), idrett – femininitet og sårbarhet? Hva er det som gjør funksjonsevne relevant og når blir den ikke relevant?

Femininitet i forhold til funksjonsevne, livsutfoldelse, lek, idrett, kjærlighetsrelasjoner

Legitim lek for voksne? Hva er fysioterapi uten lek? Leker kvinnelige og mannlige fysioterapeuter på samme måte?

Når det henvises til å være profesjonell helsearbeider – be om beskrivelser av uprofesjonell

Lytt etter rangordning av sykdommer, pasienter/brukere, helsepersonell (spesielt for kvinner med funksjonsnedsettelse)

Lytt etter hvordan det snakkes om berøring og møter med fysioterapeuter (helsepersonell) –

Lytt etter forskjeller og likheter mellom de ulike fysioterapeuter/gruppene helsepersonell – i forhold til lek, nærhet, samspill osv

Til A og T: viktige poenger til denne gruppen

Fokus på muligheter, ikke bare hindringer

Ligger det noen gevinster i å være ”dømt” til fysioterapi regelmessig eller periodevis?

Jf containerfunksjon, samtalepartner, frirom for refleksjon, utforskning av nye kroppslige praksiser eller erfaringer? Legitim tilgang til berøring, mer reflektert forhold til egen kropp?

Misfornøyd og mislykket på en arena – suksess på en annen? Smitte eller brudd?

Idrett og fysioterapi som muligheter for kroppslig utfoldning og lek som ikke er tilgjengelig for andre, med såkalte normale funksjonsevner? Sit-ski, sit-hockey, sit-basket?

Hvilke muligheter har dere for lek og kroppslige erfaringer som ikke andre har?

Femininitet – hva gjør kroppslige hindringer for full deltakelse/utfoldelse som kvinne på ulike arenaer? Identitet -

Det er kulturelt forventet at kvinner skal være kroppslig og praktisk tilgjengelig for andre – barn og voksne, og at alle kvinner skal ville ha barn og fast (fortrinnsvis mannlige) partner, skape hjem og familie, hvordan håndtere dette samtidig med de kulturelle devalueringer av kvinner med nedsatt funksjonsevne?

Praktisk: signering av samtykke/adresser/tlf/epost:

Dele ut forespørsel med samtykke og sammendrag, blankt ark, eget samtykke skjema, blyant, visittkort

Skrive samtykke med en gang før vi setter i gang, få visittkort. Sette på MD – sjekke at alle har forstått det. Minidisken står på hele tiden, inkludert samtale med Arnhild på forhånd, og etterpå. Tegne bordkart.

Hilserunde, sjekk om det er noen som ikke kjenner hverandre, spør om bruk av fornavn, sitt slik at vi ser og hører hverandre. Hente Arnhild ca kl 14.00, gruppe fra kl 17,00-19,00. Pause fra 18,00-18,15. Spør om dette er OK. Gir ca 2 ganger 45 minutter om temaet, og litt ettertid til Arnhild og Tobba. Debrifing i bilen, rydde oss ut av lokalene så fort som mulig av hensyn til NN.

Dersom jeg bruker ord og uttrykk som er uvante - spør, eller snakker for fort - stopp .
Arnhild!

Praktisk introduksjon

Jeg er nå ansatt som stipendiat på Institutt for helse- og sosialforskning på Høgskolen i Bergen for å skrive en doktorgrad. Jeg har tidligere arbeidet som lærer på Institutt for fysioterapi. Det er over 12 år siden jeg arbeidet som fysioterapeut selv.

Før jeg går videre med å fortelle litt om prosjektet mitt, skal Arnhild få presentere seg også.

☺ Arnhild får presentere seg ☺

Via NN her på huset, og NN her ved bordet, og noen som kjenner noen, har jeg samlet dere her for å diskutere hvordan fysioterapi gjøres, med utgangspunkt i deres erfaringer. Alle dere har mer eller mindre frivillig fått erfaring med fysioterapi, enten på institusjoner, på institutter eller hjemme.

Jeg skal ikke ha kontakt med den/de fysioterapeuter dere har hatt, eller har kontakt med. Det samme gjelder for leger, sykehus, institutter osv. Det er deres erfaringer og meninger som er hovedpoenget, ikke akkurat hvilken behandling, apparat eller teknikk som ble brukt eller ikke brukt.

Jeg skal ha 5 grupper med kvinner og 5 grupper med menn i dette prosjektet. Jeg har hatt to kvinnegrupper og to mannegrupper fra LHL og fra NRF. I disse gruppene er alle deltakerne langt over 50 år. Så har jeg hatt to grupper med unge friske idrettsfolk. Arnhild var med i kvinnegruppen. Jeg hadde en gruppe med unge voksne menn med ulik grad av funksjonsnedsettelse for et par uker siden, så nå er det dere her i dag som er den 8. gruppen i prosjektet. Jeg skal tilslutt ha 2 grupper, hhv kvinner og menn, som har hatt erfaring med

fysioterapi til akutte og forbigående problemer. Store og små tanker og meninger og ideer fra alle gruppene skal så settes sammen til et større bilde av fysioterapi – sett fra brukersiden – der jeg skal jakte på ulike betydninger av kjønn.

Jeg har ikke konkrete spørsmål jeg vil ha svar på som i et intervju, men noen tema som jeg ønsker at vi diskuterer. Jeg tenker at de fleste av oss vet ikke hva vi mener eller husker om et bestemt tema før vi har snakket med noen om det, fått og gitt respons på hverandres tanker, da husker vi mer, og mener mer. Denne gruppen er laget for dette formålet. Når vi snakker sammen, skapes noe annet og noe mer enn om jeg hadde intervjuet dere en og en. Det er denne kunnskapen jeg skal bruke som grunnlag for mitt videre arbeid. Alle løse tanker eller klare meninger er derfor interessante for diskusjonen.

For at jeg skal kunne bruke diskusjonen vår best mulig etterpå, er det en fordel om vi ikke snakker for mye i munnen på hverandre. Ikke fortelle mer enn dere selv vil. Husk at jeg har taushetsplikt, men ikke dere, vanlig diskresjon og høflighet holder som regel lenge.

Jeg skal styre ordet om det blir nødvendig, passe på at alle får sagt noe. Det betyr at jeg kan komme til å si til noen at de må vente litt eller direkte spørre noen som ikke har sagt så mye. Arnhild deltar i samtalen med dere, mens jeg kanskje ikke sier så mye. Jeg skal prøve å høre veldig godt etter. Noter ned det dere vil si selv så dere slipper å bruke kreftene på å huske mens de andre prater.

Faglig introduksjon

Å gjøre kjønn.....sett fra brukersiden

Det å lete etter betydninger av kjønn i fysioterapi er interessant av mange grunner. For det første er faget tydelige kjønnet, i den forstand at $\frac{3}{4}$ av alle norske fysioterapeuter er kvinner, de fleste av dem jobber i offentlig sektor, mens den mannlige fjerdedelen for det meste arbeider i privat sektor. Kvinner er interessert i barn, psykiatri, nevrologi, geriatri osv, mens menn tenderer mot manuell terapi og idrett. Både ressurser, penger og prestisje heller mot mannesiden i faget. Betydninger av kjønn i fysioterapi er også interessant fordi det ofte er langvarige forhold mellom fysioterapeuten og den han/hun behandler, det er nærhet, berøring, nakenhet, og en til en forhold, ofte i enerom.

Målet med prosjektet er å få innsikt i hvordan fysioterapi blir til, og særlig hvilken betydning kjønn har i møtet mellom bruker og fysioterapeut. Kjønn kan sees både som noe mer og noe annet enn å være mann eller kvinne. Kjønn er selvsagt biologi, så er det struktur (slik som arbeidsdeling mellom kvinnelige og mannlige fysioterapeuter, eller pensjonslovgiving), så er det identitet, og så er det symboler (farger, ting, hva som er gutt/jente måter).

Samlet preger kjønn både språk, steder, ting, aktiviteter og handlinger, og utgjør en del av rammene for et hvert møte mellom mennesker – som for eksempel et behandlingsmøte. Det gjør noe med oss om en mann kommer med høghælte rød lakksko og en liten veske, eller om det dukker opp en dame når vi venter på rørleggeren. Vi har mange regler og koder for hvordan vi skal kle oss og te oss, hvordan vi skal stå, gå eller snakke, for farger og fasonger, for å passe som mann, dame, ung, gammel osv. Disse kodene virker selv om de på mange måter er usynlige. Forstår dere?

Å gjøre kjønn i fysioterapi omfatter blant annet hvordan en tenker omkring erfaringer fra fysioterapi, hvordan en forbereder seg på forhånd, hva en forventer og opplever, erfarer eller tenker. Å gjøre kjønn handler derfor også om valg av klær, av- eller påkledning, berøring, behag og ubehag, nytelse og ytelse, kroppens utseende og fasong, fysioterapeutens forventninger, hvor mye nærhet og avstand vi ønsker eller tåler osv.

Målet er å kunne beskrive noen vilkår for gode terapeutiske forhold, særlig knyttet til kjønn og maktforhold. Å snakke om makt i forhold til en helsetjeneste er en annen måte å beskrive at det er ulike muligheter for kvinner og menn, unge og eldre, ulike diagnosegrupper og dem uten diagnose, for å få tilgang til helsetjenester, hva de faktisk får, hvordan de blir møtt, hvordan de omtales i presse, på statsbudsjetter, i lærebøker osv. Altså det at det er forskjell på kong Salomo og Jørgen Hattemaker – også i helsetjenesten. Jeg vil gjerne lære mer om hvilke forskjeller som gjør en forskjell, og hvilke som ikke tildeles noen særlig betydning i forhold til fysioterapi, men som kanskje er viktig i andre sammenhenger.

Introduksjon til denne gruppen:

5-7 voksne kvinner som av ulike grunner har erfart eller opplevd funksjonshemmende barrierer i samfunnet og/eller i dagliglivet. Dere har ulik erfaring fra fysioterapi, og noen av dere har kanskje møtt fysioterapeuten før dere var gamle nok til å si fra om dere var interessert eller ikke, og fikk behandling med eller mot egen vilje. Noen av dere er kanskje nødt til å ha kontakt med fysioterapeut i perioder i mange år enda? Dere lever med andre utfordringer i dagliglivet enn Arnhild og jeg gjør. Erfaringene deres fra fysioterapi eller andre helsetjenester vil nødvendigvis preges av der.

Spørsmål og stikkord til diskusjonen

Sett spor før og etter navnerunde, før og etter pause, og ellers så ofte du husker det. Ta en runde der alle sier navn og alder, og ”jeg har på meg en grønn genser/ har hvitt hår/ sitter på en blå stol” tydelig for stemmegjenkjenning.

Erfaringer til nå er at gruppene snakker med engang vi slipper dem løs. Gruppen kan skrive/tenke i noen få minutter, eller snakke med en gang, og dele tankene, spørsmålene og kommentarene med hverandre. Ta en runde rundt bordet, beskrive for hverandre, spørre om noen har spørsmål eller kommentarer til de andre. Bytt på rekkefølge om det blir nødvendig

- Kan dere fortelle hverandre hvilke tanker eller assosiasjoner dere fikk da dere ble spurt om å delta i her i kveld?
- Eventuelt: hva tenker dere etter at dere har hørt det jeg sa nå?
- Kan dere summe dere i 2 minutter, ta en kopp kaffe el lignende, og let etter en situasjon der kjønn ble tydelig i møte med en fysioterapeut (eller en annen helseprofesjon)? Hva skjedde da? Hvorfor ble kjønn tydelig?

- Kan dere fortelle noe om hvordan dere forbereder dere på å gå til fysioterapeut? Hvilken betydning har alder eller kjønn her?
- Kan dere fortelle med noen stikkord om forskjeller og likheter på lokalene hos kvinnelige eller mannlige fysioterapeuter, eller private institutter og offentlige sykehus/poliklinikker? Hvilke tanker har dere omkring forskjeller/likheter?
- Kan dere kort beskrive drømme-fysioterapeuten deres? Og mareritt-fysioterapeuten? Tror dere dette henger sammen med problem eller kjønn
- Er det forskjell på hva en snakker om? Mat, jakt, fiske, hagestell, gardiner, barn, familie, sport, spill, trening?
- Tror dere det kan oppstå misforståelser mellom fysioterapeuten og brukeren når det både er avkledding og berøring? Hvorfor blir det slik? Flørt og lek? Grenser eller terapi? Er det forskjell på hvor på kroppen det berøres?
- Tror dere at alle mennesker ønsker eller tåler samme grad av nærhet til en fysioterapeut? Vet dere om noen som har fått for mye eller for lite?
- Hvordan bruker fysioterapeutene hendene eller maskiner/apparater? Hvordan eller på hvilke måter kjenner dere forskjell på de ulike fysioterapeutene?
- Hvilken betydning har alder, eller det å bo i by eller på landet, små kommuner eller bygder? Tror dere det kunne vært annerledes å gå til en FT i en større by der ikke alle kjenner til hverandre?
- Dersom dere har vært hos andre typer behandlere; hvilke forskjeller legger dere merke til? – ergoterapi, kiropraktor, naprapat, homøopat, thaim massasje, aromaterapi, osteopati, annet?
- Kan dere merke forskjell på terapeuter som er utdannet i Norge og i utlandet?

Avrundning

- Hvordan tror dere diskusjonen hadde vært her om vi hadde hatt med menn også?
- Hvordan tror dere at diskusjonen hadde vært om dere var her, men at både Arnhild og jeg var menn?
- Om dere var forskere, og Arnhild og jeg var med i en gruppe, hva ville dere spurt meg om, eller oss om?
- Kan dere helt til slutt oppsummere med noen stikkord om hva som var det viktigste vi har snakket om i dag?
- Hva synes dere jeg skal spørre de siste gruppene mine om?

- Hva vil dere at jeg skal bringe tilbake til neste generasjons fysioterapeuter? Hva skal vi utdanne dem til?

Takke for i dag 😊 husk å dele ut gavene!

Spørre om lov til å kontakte dem enkeltvis på telefon, epost eller brev om det er noe jeg lurer på. Oppfordre til å ringe eller skrive om de får nye tanker.

Til Arnhild – notatet overlevert tirsdag 9. september 2004

1. Jeg vet ikke om deltakerne kjenner hverandre fra før, sjekkes ut.
2. Åpne spørsmål, diskusjonen er hele poenget med en gruppe!
3. Kan du tenke litt og høre etter på hvordan jeg innleder. Om det blir forskjellig fra sist, eller om det finnes andre måter å sette i gang en diskusjon på.
4. Kan du hjelpe meg med å oppfordre gruppen til å kommentere hverandre? Jeg ønsker at du prøver å hjelpe gruppen til å diskutere med hverandre. De fleste vet hva intervjuer er – og vil kanskje tenke at dette er bare et intervju med mange deltakere på en gang. Som vi har erfart i fellesskap skjer det noe annet og noe mer når vi snakker sammen, enn når vi snakker til noen.
5. Dersom noen spør meg om konkrete detaljer fra fysioterapi må du hjelpe meg eller minne meg på å kjønne svaret – f. eks som da de spurte om inntekt – burde jeg svart kort i relasjon til inntekt, kjønn, fagfelt, arbeidssted, by og land osv.
6. Dette er du god på Arnhild: Når dere snakker slik om X, så tror jeg det er det samme som Y, eller det motsatte av Z, eller det samme som C....Hva tror dere om det?” Jeg har tidligere hørt at NN har fortalt bla-bla, har dere hørt noen si det? Er dette det samme som det NN sier her? Jeg tror at dersom jeg skulle gå til FT ville jeg grue meg, glede meg, ikke bry meg om bla-bla, men tenke mye på bla-bla, - hvordan tenker dere?
7. Jeg tror kanskje det kan være lurt å spørre innimellom – tenke om du var eldre, terapeuten var yngre, vi var kvinner ikke menn, terapeuten var mann/kvinne, eller hadde en annen plage, hadde en plage som var usynlig/hadde et problem som var usynlig – slik at vi lager kontraster for å få øye på kjønn og maktstrukturer indirekte.
8. Flere ganger har deltakerne vist til at ” de er jo profesjonelle”, slik at alder, kjønn, seksualitet eller annet rusk underforstått ikke er relevant for situasjonen. Kanskje vi skulle spørre om hva de tror ville skjedd dersom terapeuten var uprofesjonell
9. Dersom du kommer på noe må du bare hive deg frampå. Jeg tenker at du som min medarbeider, kan delta i diskusjonen og trekke de andre med deg, på en god måte. Om du må snakke mye eller lite vet vi vel ikke på forhånd.

Abstract til konferansen “Den gode, den onde, den normale”
Nordisk mannsforskningskonferanse 26-28 november 2004
(må bli et 10 siders paper innen 1. oktober)

Lek + maskulinitet = terapi?

Norsk fysioterapi er en tydelig kjønnet og hierarkisert praksisform, med tanke på kunnskapsgrunnlag, arbeidsdeling, spesialisering, ressurstilgang, og spesialiteter og sykdommer/funksjonsproblemers prestisje. Kunnskapsgrunnlaget i fysioterapi hentes hovedsaklig fra medisin, og en av fire norske fysioterapeuter er menn. De mannlige fysioterapeutene arbeider oftest i privat sektor, med manuell terapi eller idrett, har gode materielle ressurser, og stor grad av kontroll over eget arbeid. De kvinnelige fysioterapeutene arbeider oftest i offentlig sektor med barn, eldre, kronisk syke eller psykiatri, har mindre tilgang på materielle ressurser, og mindre kontroll over eget arbeid.

Fysioterapi som praksis forsterker stereotype kjønnsroller når behandleren er en mann og pasienten er en kvinne. Ofte er det omvendt; kvinnelig terapeut og mannlig pasient. Stereotypiene inverteres, og partene må håndtere kroppslig nærhet, seksualitet og inverterte kjønnsroller samtidig som de gjør fysioterapi.

Dette paperet vil diskutere hvordan kjønn gjøres i fysioterapi, sett fra brukernes ståsted, med utgangspunkt i ulike inntak til lek og maskulinitet. Lek kan være en måte å utforske og forstå en situasjon på, prøve ut nye strategier og handleformer, og gi ny betydning til tidligere kroppslige erfaringer. Ved å analyseres samspillet mellom terapeut og voksne brukere/pasienter som lek, kan mannlige terapeuter framstå som lekende “fedre”, og kvinnelig fysioterapeuter framstå som trøstende “mødre”. Kvinner og menns lek får ulike moralske konnotasjoner og legitimitet. Ulike konstruksjoner av maskulinitet diskuteres som en grunnleggende betingelse i kunnskapsgrunnlaget i fysioterapi for hierarkisering og prestisje, og for utforming av ulike behandlingsideologier og praksisformer – sett som lek. Diskusjonene henter teoretisk inspirasjon fra Foucault og Gadamer, og diskursanalytiske tilnærminger til maskuliniteter.

